

A SHORT HISTORY OF ASSISTED SUICIDE IN MONTANA

By Margaret Dore, Esq.

A. Assisted Suicide

In 1895, the Montana Legislature enacted a criminal statute prohibiting assisted suicide as a "crime against the public safety."¹ In 1907, 1921 and 1947, this statute was re-codified, but its text remained unchanged.² The statute stated:

Every person who deliberately aids, or advises or encourages another to commit suicide is guilty of a felony.³

B. The Constitutional Convention

In 1972, Montana held its constitutional convention. At that time, the convention's Bill of Rights Committee considered and rejected a proposed "right to die."⁴ The testimony supporting this proposal had included an argument to allow physician-assisted suicide in the case of a painful death.⁵

¹ Section 698, Pen. C. 1895.

² In 1907, § 698, Pen. C. 1895 was reenacted as § 8529, Rev. C. 1907. In 1921, the statute was reenacted as § 11261, R.C.M. In 1947, the statute was reenacted as § 94-35-215.

³ Id.

⁴ See Margaret Dore, "Montana Constitution Does Not Include a 'Right to Die,'" at, updated January 20, 2013, at www.montanansagainstaassistedsuicide.org/p/no-right-to-die.html

⁵ Id, stating: "On February 3, 1972, the Committee held a hearing on the "right to die." [2] According to the Committee Minutes, "Mrs. Joyce Franks presented the theory to the Committee that all persons should be able to choose his own death with dignity." [3] The record also includes her seven page written submission, titled "Bill of Rights Speech." [4] In this document, she proposed wording for a constitutional right to die; she discussed her father's long and painful death, and the right to die in terms of physician-assisted suicide and/or euthanasia. [5]" (Mrs. Franks' testimony form and seven page document are available at <http://maasdocuments.files.wordpress.com/2012/10/archived-mrs-franks-materials-02-03-721.pdf>) Links to other archived documents are available here, in the footnotes: www.montanansagainstaassistedsuicide.org/p/no-right-to-die.html

On June 6, 1972, the constitution was ratified by the people without the proposed right to die.⁶ This is the present Constitution of the State of Montana.⁷

C. A New Criminal Code

In 1973, the Legislature enacted a new criminal code drafted by the Criminal Law Commission. The new Code moved the prohibition against aiding a suicide to the homicide statutes.⁸ If the suicide occurred, the offense would be homicide.⁹ If the suicide did not occur, the offense would be "aiding or soliciting suicide."¹⁰ The Criminal Law Commission Comments stated that a victim's consent was not a defense, as follows:

If the conduct of the offender made him the agent of the death, the offense is criminal homicide, *notwithstanding the consent or even the solicitations of the victim.* (Emphasis added)¹¹

The new Code did not, however, provide this clarifying information in the statutes themselves.

In 1981, the Legislature added a monetary penalty.¹²

⁶ Margaret Dore, at www.montanansagainstaassistedsuicide.org/p/no-right-to-die.html

⁷ Id.

⁸ 45-5-105, MCA, "Aiding or soliciting suicide," is part of Title 45, Crimes, Chapter 5, Offenses Against the Person, Part 1, Homicide. See Table of Contents attached hereto at A-64.

⁹ See Montana Legislative Services Division, *2012 Annotations to the Montana Code Annotated*, p. 271, Annotator's Note regarding 45-5-105, MCA, ("Under the new sections . . . a person may be convicted of Criminal Homicide . . . for causing another to commit suicide . . .") (Attached at A-67).

¹⁰ 45-5-105(1), MCA states: "A person who purposely aids or solicits another to commit suicide, but such suicide does not occur, commits the offense of aiding or soliciting suicide." (Attached at A-68).

¹¹ Montana Legislative Services Division, *2012 Annotations to the Montana Code Annotated*, p. 270, Criminal Law Commission Comments regarding 45-5-105, MCA. (Attached hereto at A-66)

¹² See 45-5-105(2) and 45-5-103(4), MCA. (Attached at A-68 & A-69).

D. Civil Liability

In 1989, the Supreme Court of Montana issued *Krieg v. Massey*, describing that civil liability can be imposed against a person who causes or fails to prevent another person's suicide.¹³

E. *Baxter v. State*

On December 8, 2008, a Montana district court judge issued a decision holding that patients have a right to physician-assisted suicide under the Montana State Constitution.¹⁴ On December 31, 2009, the Supreme Court of Montana vacated this decision in *Baxter v. State*.¹⁵ The vote to vacate was six justices to one.¹⁶

In *Baxter*, the Supreme Court also held that a patient's consent to assisted suicide is a defense to a homicide charge

¹³ *Krieg*, 239 Mont. 469, 472-3 (1989) states:

The general rule . . . is that "[n]egligence actions for the suicide of another will generally not lie since the act or suicide is considered a deliberate intervening act exonerating the defendant from legal responsibility . . .

There are two . . . exceptions to this rule. The first exception deals with causing another to commit suicide . . . The second exception allows the imposition of a duty to prevent suicide but only in a custodial situation where suicide is foreseeable. These situations typically involve hospitals or prisons.

¹⁴ *Baxter v. State*, 354 Mont. 234, ¶¶ 7 & 9, 224 P.3d 1211, 2009 MT 449,

¹⁵ *Id.*, ¶ 51

¹⁶ In *Baxter*, Justice James Nelson, specially concurring, was the only justice who voted to affirm a constitutional right to physician-assisted suicide under the Montana State Constitution. See his concurrence beginning at ¶ 64. The majority opinion issued by Justice William Leaphart vacated the district court's constitutional ruling at ¶ 51 ("The District Court's ruling on the constitutional issues is vacated . . .") Leaphart was joined by Justices Patricia O. Cotter, John Warner and Brian Morris. Warner's concurrence, ¶ 54, states "This Court correctly avoided the constitutional issue . . ." The dissent by Justice Jim Rice, joined by Joe L. Hegel, would have gone farther to state that there is no constitutional right to assisted suicide under the Montana State Constitution. See ¶¶ 111-116.

against an assisting physician.¹⁷ The Court said that it was not bound by the Criminal Law Commission Comments, providing that a victim cannot consent, because that language did not appear in the statutes themselves.¹⁸ Again, the Criminal Law Commission Comments state:

If the conduct of the offender made him the agent of the death, the offense is criminal homicide, *notwithstanding the consent or even the solicitations of the victim.* (Emphasis added)¹⁹

The Supreme Court's decision was also based on a determination that assisted suicide is not against Montana public policy.²⁰ The Court, however, overlooked elder abuse. *Baxter* states that the only person "who might conceivably be prosecuted for criminal behavior is the physician who prescribes a lethal dose of medication."²¹ *Baxter* thereby overlooked criminal behavior by family members and others who benefit from a patient's death, for example, due to an inheritance. The Court thereby overlooked Montana's explicit public policy to prevent elder abuse.²²

The Court also failed to address its own precedent imposing liability on persons who cause or fail to prevent a suicide.²³

¹⁷ *Baxter*, 354 Mont. at 251, ¶ 50, states: "We . . . hold that under § 45-2-211, MCA, "a terminally ill patient's consent to physician aid in dying constitutes a statutory defense to a charge of homicide against the aiding physician when no other consent exceptions apply."

¹⁸ The Court stated: "[T]he comments analyze language, such as 'agent of death,' that does not even appear in the aid or soliciting statute or anywhere else in the Montana code." *Baxter*, 354 Mont. at 249, ¶ 42.

¹⁹ Montana Legislative Services Division, *2012 Annotations to the Montana Code Annotated*, p. 270, Criminal Law Commission Comments regarding 45-5-105, MCA. (Attached at A-66)

²⁰ *Baxter*, 354 Mont. at 250, ¶ 49.

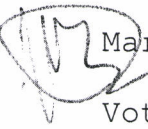
²¹ *Baxter*, 354 Mont. at 239, ¶ 11.

²² See e.g., the Montana Elder and Persons With Developmental Disabilities Abuse Prevention Act, 52-3-801, MCA; the Protective Services Act for Aged Persons or Disabled Adults, 52-3-201, MCA; and the "Montana Older Americans Act," 52-3-501, et. al., MCA.

²³ *Baxter* does not mention civil liability or professional discipline.

MEMORANDUM

TO: Senate Judiciary Committee

FROM:  Margaret Dore, Esq.

RE: Vote No on SB 220. (No Assisted Suicide)

HEARING: February 11, 2013 at 10 a.m.

DATE: February 7, 2013

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I. INTRODUCTION

I am an attorney in Washington State where assisted suicide is legal.¹ Our law is modeled on Oregon's law. Both laws are similar to SB 220.²

This memo discusses why the claim that SB 220 will assure patient control is untrue. SB 220 is instead a recipe for elder abuse. The bill puts the elderly in the crosshairs of their heirs and abusive family members.

SB 220 also eliminates safeguards such as waiting periods that supposedly render the Oregon and Washington laws safe.³ Doctor reporting is also eliminated.⁴ The former Hemlock Society, Compassion & Choices, claims that this is because Oregon's reporting system has "demonstrated the safety of the

¹ I am an elder law/appellate attorney in Washington state who has been licensed to practice law since 1986. I am a former Law Clerk to the Washington State Supreme Court. I am a former Chair of the Elder Law Committee of the American Bar Association Family Law Section. I am also President of Choice is an Illusion, a nonprofit corporation opposed to assisted suicide. For more information, see www.margaretdore.com and www.choiceillusion.org

² A copy of SB 220 is attached hereto at A-1 through A-13.

³ The Oregon and Washington laws have a 15 day waiting period and a 48 hour waiting period. See ORS 127.850 § 3.08 & RCW 70.245.110. SB 220 does not. Oregon's and Washington's laws require a second "consulting" doctor. See ORS 127.820 § 302 & RCW 70.245.050. SB 220 makes the second doctor "waivable," i.e., not required. See SB 220 § 7. Oregon and Washington require two oral requests. See ORS 127.840 § 306 & RCW 70.425.090. SB 220 requires one oral request and a written request. See SB 220, § 4.

⁴ Oregon's and Washington's laws require doctor reporting to a Department of Health type entity. See ORS 127.865 § 3.11 & RCW 70.245.150. SB 220 does not.

practice.”⁵ To the contrary, Oregon’s reports support that the claimed safety is speculative. The reported statistics are also consistent with elder abuse. No wonder Compassion & Choices wants the reporting system gone.

II. FACTUAL AND LEGAL BACKGROUND

A. Compassion & Choices is a Successor Organization to the Hemlock Society

Compassion & Choices was formed in 2004 as the result of a merger/takeover of two other organizations.⁶ One of these organizations was the former Hemlock Society, originally formed by Derek Humphry.⁷

In 2011, Humphry was the keynote speaker at Compassion & Choices’ annual meeting here in Washington State.⁸ In 2011, he was also in the news as a promoter of mail-order suicide kits.⁹ This was after a depressed 29 year old man used one of the kits to kill himself.¹⁰

⁵ See Compassion & Choices’ Handout, “Montana Physicians Can Now Respect Dying Patients’ Decisions, [etc],” passed out as part of a media packet, January 27, 2011.

⁶ See Ian Dowbiggin, *A Concise History of Euthanasia* 146 (2007) (“In 2003, [the] Hemlock [Society] changed its name to End-of-Life Choices, which merged with Compassion in Dying in 2004, to form Compassion & Choices”) and Compassion & Choices Newsletter excerpt attached hereto at A-14.

⁷ Id.

⁸ See Compassion & Choices newsletter at A-14.

⁹ Randi Bjornstad, “Suicide Kits Sell Death by Mail,” *The Register-Guard*, March 20, 2011, at A-17 (“All roads lead to Derek Humphry”).

¹⁰ Id. (Excerpts at A-15 through A-17).

B. Physician-assisted Suicide

The American Medical Association (AMA) defines physician-assisted suicide as occurring "when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act."¹¹ An example would be a doctor's prescription for a lethal drug to facilitate a patient's suicide.¹² The AMA rejects this practice, stating:

Physician-assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.¹³

C. Most States Have Rejected Assisted Suicide

There are just two states where physician-assisted suicide is legal: Oregon and Washington. Oregon's assisted suicide act was enacted via a ballot initiative in 1997.¹⁴ Washington's similar act was enacted via another initiative in 2008 and went into effect in 2009.¹⁵ No such law has made it through the

¹¹ AMA Code of Medical Ethics, Opinion 2.211, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2211.page>

¹² Id.

¹³ Id.

¹⁴ Oregon's physician-assisted suicide act was passed as Ballot Measure 16 in 1994 and went into effect after a referendum in 1997.

¹⁵ Washington's act was passed as Initiative 1000 on November 4, 2008 and went into effect on March 5, 2009. See <http://www.doh.wa.gov/dwda/default.htm>

scrutiny of a legislature despite more than 100 attempts.¹⁶ In the last two years, three states have strengthened their laws against assisted suicide.¹⁷ Those states are: Idaho; Georgia; and Louisiana.¹⁸

III. THE BILL

A. How SB 220 Works

SB 220 first has an application process to obtain the lethal dose, which includes a written lethal dose request form.¹⁹

Once the lethal dose is issued by the pharmacy, there is no oversight. The death is not required to be witnessed by disinterested persons.²⁰ Indeed, no one is required to be present.²¹

B. Patients are Not Necessarily Dying

SB 220 applies to patients with a "terminal illness," which is defined as having less than six months to live.²² Such persons are not necessarily dying and may have years to live.

¹⁶ See tabulation at http://epcdocuments.files.wordpress.com/2011/10/attempts_to_legalize_001.pdf

¹⁷ See Margaret Dore, "US Overview," updated July 30, 2012, at <http://www.choiceillusion.org/p/us-overview.html>

¹⁸ Id.

¹⁹ The request form can be viewed at SB 220, § 11. (Attached at A-6 & A-8)

²⁰ See SB 220 in its entirety. (Attached at A-1 through A-13).

²¹ Id.

²² SB 220, § 2(15). (Attached at A-2).

This is because doctor predictions of life expectancy can be wrong.²³

Consider also Oregon resident, Jeanette Hall, who was diagnosed with cancer in 2000 and wanted to do assisted suicide.²⁴ Her doctor convinced her to be treated instead.²⁵ In a recent affidavit, she states:

This July, it was 12 years since my diagnosis. If [my doctor] had believed in assisted suicide, I would be dead.²⁶

IV. ARGUMENT

A. Patient "Control" is an Illusion

Proponents claim that SB 220 will assure patient control.²⁷ This is untrue.

1. No witnesses at the death

As set forth above, SB 220 does not require witnesses to be present at the patient's death. Without disinterested witnesses,

²³ Nina Shapiro, *Terminal Uncertainty - Washington's new 'Death with Dignity' law allows doctors to help people commit suicide - once they've determined that the patient has only six months to live. But what if they're wrong?*, Seattle Weekly, January 14, 2009, available at www.seattleweekly.com/2009-01-14/news/terminal-uncertainty. (Attached at A-18 to A-23). See also Affidavit of Kenneth Stevens, MD, September 18, 2012 (attached at A-24 to A-30); and Affidavit of John Norton (when he was eighteen years old, he was told that he would die of ALS and paralysis in three to five years; he is now 75 years old). (Attached at A-31).

²⁴ Affidavit of Kenneth Stevens, MD, ¶¶ 3-7, described above at note 23; Affidavit of Jeanette Hall Opposing Assisted Suicide, August 17, 2012 (Attached at A-34).

²⁵ Id.

²⁶ Affidavit of Jeanette Hall, ¶ 4. (Attached at A-35)

²⁷ Compassion & Choices' Handout, *supra* at note 5.

the opportunity is created for someone else to administer the lethal dose to the patient without his consent.²⁸ Even if he struggled, who would know?

Without witnesses, the patient's control over his death is not guaranteed.

2. Someone else is allowed to speak for the patient

Under SB 220, patients signing the lethal dose request form are required to be "competent."²⁹ This is, however, a relaxed standard in which someone else is allowed to speak for the patient. SB 220 states:

"Competent" means that . . . the patient has the ability to make and communicate an informed decision . . ., *including communication through persons familiar with the patient's manner of communicating . . .*" *Emphasis added*). (Emphasis added).³⁰

There is no requirement that the person speaking for the

²⁸ The drugs used, Secobarbital and Pentobarbital (Nembutal), are water soluble, such that they can be injected without consent, for example, to a sleeping person. See "Secobarbital Sodium Capsules, Drugs.Com, at <http://www.drugs.com/pro/seconal-sodium.html> and <http://www.drugs.com/pro/nembutal.html> See also Oregon's report, attached at A-40 (listing these drugs).

²⁹ SB 220 § 2(12). (Attached at A-2).

³⁰ SB 220 § 2(3) states:

"Competent" means that, in the opinion of a court or in the opinion of a patient's attending physician, consulting physician, psychiatrist, or psychologist, the patient has the ability to make and communicate an informed decision to health care providers, including communication through a person familiar with the patient's manner of communicating if that person is available.

Attached at A-1.

patient be a designated agent such as an attorney in fact. The person could be an heir or new "best friend" who would benefit from the patient's death. The patient would not necessarily be in control of his fate.

3. Legal capacity for treatment decisions is not required when requesting the lethal dose

Under SB 220's definition of "competent," there is no requirement that a patient signing the lethal dose request form have the ability to make "responsible" or "rational" decisions, which is the definition of legal capacity for treatment decisions in Montana.³¹ Yet again, the patient would not necessarily be in control.

4. Consent is not required when the lethal dose is administered

SB 220 does not require competency or even awareness when the lethal dose is administered.³² SB 220 does not require the

³¹ Compare SB 220's definition of "competent" in § 2(3) and 72-5-101(1), MCA, which states:

"Incapacitated person" means any person who is impaired by reason of mental illness, mental deficiency, physical illness or disability, chronic use of drugs, chronic intoxication, or other cause, except minority, to the extent that the person lacks sufficient understanding or capacity to make or communicate responsible decisions concerning the person or which cause has so impaired the person's judgment that the person is incapable of realizing and making a rational decision with respect to the person's need for treatment. (Emphasis added).

³² SB 220 requires that a determination of "competent" be made in conjunction with the lethal dose request, not later. See SB 220, §§ 2(3), (5) & (12); § 3(1)(a); § 4(2)(c)(i); § 6(1)(a)(iii) & (c). Optional determinations of competency are also made in conjunction with the lethal dose request, not later. See e.g. SB 220, §§ 7(1)(c)(i).

patient's consent when the lethal dose is administered.³³

Without the right of consent at the time of death, the patient's control over his death is an illusion.³⁴

5. Individual "opt outs" are not allowed

SB 220 says that a provision in a will or contract that affects whether a patient may make or rescind a lethal dose request "is not valid."³⁵

So if you are a person who gets talked into things, and you don't want to get talked into suicide (or facilitating your own homicide), you are not allowed to make legal arrangements to try and prevent it.

So much for your personal "control."

³³ SB 220 requires that a determination of "voluntariness" be made in conjunction with the lethal dose request, not later. See e.g. SB 220 §§ 3(1)(d); 4(2)(c)(ii) & (iii); and 6(1)(a)(iv). There is no requirement that the patient be acting on a voluntary basis at the time of administration. See SB 220 in its entirety. (Attached at A-1 through A-13).

³⁴ Proponents may counter that patients are nonetheless protected because they may rescind the request for the lethal dose "at any time." (SB 220 §5, attached at A-4). The fact that a patient may rescind is not the same thing as a right to give consent when the lethal dose is administered. Consider a patient who obtained the lethal dose on a "just-in-case" basis without consenting to taking it. If such person would later become incompetent, be sedated, or simply be asleep, he or she would not have the ability to rescind. Without the right to consent, someone else could, nonetheless, legally, administer the lethal dose to that person. Proponents may also argue that patients are protected due to provisions imposing civil and criminal liability. (SB 220 §17). None of these provisions penalize administration of the lethal dose without the patient's consent. (Id.).

³⁵ SB 220 § 13(1) states:

A provision in a contract, will, or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end the person's life in a humane and dignified manner, is not valid.

B. Word Play

Proponents may claim that patients are nonetheless in control due to: "self-administration"; and a prohibition against euthanasia. These arguments are wordplay.

1. "Self-Administer" allows someone else to administer the lethal dose

SB 220 states that patients "may" self-administer the lethal dose.³⁶ There is no provision that administration of the dose "must" be by self-administration.³⁷

SB 220 also defines "self-administer" as the patient's "act of ingesting."³⁸ SB 220 does not define "ingest." Dictionary definitions include:

[T]o take (food, drugs, etc.) into the body,
as by swallowing, inhaling, or absorbing."
(Emphasis added).³⁹

With these definitions, someone else putting the lethal dose in the patient's mouth qualifies as proper administration because the patient will thereby be "swallowing" the lethal dose, *i.e.*, "ingesting" it. Someone else placing a medication patch on the patient's arm will also qualify because the patient will thereby

³⁶ See SB 220 §2(8) & (12).

³⁷ See SB 220 in its entirety, attached hereto at A-1 to A-13.

³⁸ SB 220 §2(14), states: "*Self-administer*" means a qualified patient's act of ingesting medication to end the qualified patient's life . . ."
(Emphasis added).

³⁹ Webster's New World College Dictionary, ingest. (Attached at A-42).

be "absorbing" the dose, i.e., "ingesting" it. Gas administration, similarly, qualifies because the patient will thereby be "inhaling" the dose, i.e., "ingesting" it. With self-administer defined as mere ingesting, someone else is allowed to administer the lethal dose to the patient.

2. This is euthanasia

Allowing someone else to administer the lethal dose to the patient is "euthanasia." The AMA Code of Medical Ethics, Opinion 2.21, states:

Euthanasia is the administration of a lethal agent by another person to a patient . . .

Attached hereto at A-43.

3. Euthanasia is not prohibited

SB 220 appears to prohibit "euthanasia," which is another name for mercy killing.⁴⁰ SB 220 states:

Nothing in [this act] may be construed to authorize a physician or any other person to end a patient's life by . . . mercy killing, or active euthanasia.⁴¹

This prohibition is, however, defined away in the next sentence. SB 220 states:

Actions taken in accordance with [this act] may not, for any purposes constitute . . . mercy killing [also known as "euthanasia"] .

⁴⁰ See <http://medical-dictionary.thefreedictionary.com/mercy+killing> (defining "mercy killing" as euthanasia). (Attached at A-44).

⁴¹ SB 220, § 20. (Attached at A-12).

. . . "42

C. Legalization will Create New Paths of Elder Abuse

In Montana, there has been a rapid growth of elder abuse.⁴³ "Elders' vulnerabilities and larger net worth make them a prime target for financial abuse."⁴⁴ "Victims may even be murdered by perpetrators who want their funds and see them as an easy mark."⁴⁵

Abuse of the elderly is often difficult to detect. This is due in part to the unwillingness of victims to report. An article on KULR8.com, states: "often time the victimizer is a family member and the elderly victim doesn't want to get them into trouble."⁴⁶

In Montana, preventing elder abuse is official state

⁴² *Id.*

⁴³ See Great Falls Tribune, *Forum will focus on the rapid growth in abuse of elders*, June 10 2009 ("The statistics are frightening, and unless human nature takes a turn for the better, they're almost certain to get worse"). (Attached at A-45). See also Nicole Grigg, *Elder Abuse Prevention*, Kulr8.com, June 15, 2010, <http://www.kulr8.com/internal?st=print&id=96428934&path=/news/local> (attached at A-46); and Big Sky Prevention of Elder Abuse Program, *What is Elder Abuse*, <http://www.mtelderabuseprevention.org/whatis.html>. (Attached at A-47).

⁴⁴ MetLife Mature Market Institute, "Broken Trust: Elders, Family and Finances, A Study on Elder Abuse Prevention," March 2009, p.4, available at <http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf>

⁴⁵ *Id.* at page 24.

⁴⁶ Nicole Grigg, attached at A-46.

policy.⁴⁷ If assisted suicide is legalized, new paths of abuse will be created against the elderly, which is contrary to that policy. Alex Schadenberg, chair for the Euthanasia Prevention Coalition, International, states:

With assisted suicide laws in Washington and Oregon, perpetrators can . . . take a "legal" route, by getting an elder to sign a lethal dose request. Once the prescription is filled, there is no supervision over the administration. . . . [E]ven if a patient struggled, "who would know?"⁴⁸

V. THE OREGON EXPERIENCE

A. Law Enforcement is Barred From Reported Information

Deaths under Oregon's assisted suicide act are not required to be reviewed by a medical examiner or coroner.⁴⁹ Instead, the Oregon Department of Human Services is charged with collecting information for the purpose of an annual statistical report.⁵⁰ According to Oregon's act, this information "shall not be a public record and may not be made available for inspection by the

⁴⁷ See the "Montana Elder and Persons With Developmental Disabilities Abuse Prevention Act," 52-3-801, MCA; the Protective Services Act for Aged Persons or Disabled Adults, 52-3-201, MCA; and the "Montana Older Americans Act," 52-3-501, et. al., MCA.

⁴⁸ Alex Schadenberg, Letter to the Editor, *Elder abuse a growing problem*, *The Advocate*, October 2010, page 14, available at http://www.margaret-dore.com/info/October_Letters.pdf (Attached at A-51).

⁴⁹ See Oregon's entire act, ORS 127.800-.897.

⁵⁰ See ORS 127.865 § 3.11(3) ("The department shall generate and make available to the public an annual statistical report . . .").

public."⁵¹ Moreover, this language has been interpreted to bar access by law enforcement. Alicia Parkman, Mortality Research Analyst with the Oregon Health Authority, wrote me as follows:

For all of your questions, [including whether we would "release copies of completed reporting forms in answer to a request by law enforcement,"] the answer is no.⁵²

She also stated:

We can neither confirm nor deny participation of any individual patient or physician. We have been contacted by law enforcement and legal representatives in the past, but have not provided identifying information of any type.⁵³

B. Oregon's Annual Statistical Report

The preamble to Oregon's most recent annual statistical report implies that all of the deaths under the act were voluntary (self-administered).⁵⁴ The information provided in the report does not, however, address whether the deaths were voluntary.⁵⁵ For example, there is no information provided as to

⁵¹ ORS 127.865 § 3.11(2), states: "Except as otherwise required by law, the information collected shall not be a public record and may not be made available for inspection by the public."

⁵² E-mail from Alicia Parkman to Margaret Dore, January 4, 2012 (Attached hereto at A-52).

⁵³ Id.

⁵⁴ The report is attached hereto at A-36.

⁵⁵ The report (at A-36 though A-41) instead focuses on the patient's "ingestion" of the lethal dose, i.e., whether the patient swallowed, inhaled or absorbed the dose, which as described above, would not necessarily require a volitional act by the patient. A patient could also voluntarily swallow the lethal dose, but not know what it was, or be drunk, or be otherwise incapacitated so as to "ingest" the lethal dose, but not give consent.

whether the patients consented to administration of the lethal dose.⁵⁶

The report does, however, provide the following demographics. Most of the persons who died under Oregon's act were age 65 and older.⁵⁷ They were also white and well-educated; many had private insurance.⁵⁸

Typically, persons with these attributes would be seniors with money, which would be the middle class and above, a group disproportionately at risk of financial abuse and exploitation.⁵⁹ Oregon's recent report is thereby statistically consistent with elder financial abuse. Again, this explains why Compassion & Choices has drafted SB 220 to eliminate such reporting in Montana.

C. Any Study Claiming that Oregon's Law is Safe, is Invalid

During Montana's last legislative session, the lack of oversight over administration in Oregon's law prompted Senator

⁵⁶ Id.

⁵⁷ Oregon's report for 2012 states: "'Of the 77 DWDA deaths during 2012, most (67.5%) were aged 65 years or older.'" (Attached at A-37)

⁵⁸ Oregon's report states: "As in previous years, most were white (97.4%), [and] well-educated (42.9% had at least a baccalaureate degree)." (Attached at A-37). The report also states: "Excluding unknown cases, all (100.0%) had some form of health insurance, although the number of patients who had private insurance (51.4%) was lower than in previous years(66.2%) . . ." Id.

⁵⁹ See "Broken Trust: Elders, Family, and Finances, a Study on Elder Financial Abuse Prevention, by the MetLife Mature Market Institute, page 4 ("Elders' vulnerabilities and larger net worth make them a prime target for financial abuse"), available at <http://www.metlife.com/assets/cao/mmi/publications/studies/mmi-study-broken-trust-elders-family-finances.pdf>

Essmann to make this observation: the Oregon studies are invalid.
He stated:

[All] the protections end after the prescription is written. [The proponents] admitted that the provisions in the Oregon law would permit one person to be alone in that room with the patient. And in that situation, there is no guarantee that that medication is self administered.

So frankly, any of the studies that come out of the state of Oregon's experience are invalid because no one who administers that drug . . . to that patient is going to be turning themselves in for the commission of a homicide.⁶⁰

D. Steerage

In Oregon, legalization of physician-assisted suicide has also empowered the Oregon Health Plan (Medicaid) to steer patients to suicide. The most well known cases are Barbara Wagner and Randy Stroup.⁶¹ Each wanted treatment.⁶² The Plan denied coverage for treatment and offered to pay for their suicides instead.⁶³ Wagner was devastated.⁶⁴ She said "I'm not

⁶⁰ See link to hearing transcript for SB 167, February 10, 2011, http://www.margaretdore.com/pdf/senator_essmann_sb_167_001.pdf

⁶¹ See Susan Donaldson James, "Death Drugs Cause Uproar in Oregon," ABC News, August 6, 2008 (attached at A-53 to A-57), available at <http://abcnews.go.com/Health/story?id=5517492&page=1> and KATU TV, "Letter noting assisted suicide raises questions," KATU TV, July 30, 2008 (attached at A-58), at <http://www.katu.com/news/specialreports/26119539.html>

⁶² Id.

⁶³ Id.

⁶⁴ Id.

ready to die."⁶⁵ Stroup said "This is my life they're playing with."⁶⁶

Today, the Oregon Health Plan continues to use financial incentives to steer patients to suicide. Oregon doctor, Kenneth Stevens, explains:

8. . . . The Plan covers the cost [of the suicide]. . . .

9. Under the . . . Plan, there is also a financial incentive towards suicide because the Plan will not necessarily pay for a patient's treatment. For example, patients with cancer are denied treatment if [they fit within] "Guideline Note 12." . . .

11. Some of [these patients, if treated,] will likely live . . . as much as five, ten or twenty years depending on the type of cancer. This is because there are always some people who beat the odds.

12. All such persons who fit within "Guideline Note 12" will nonetheless be denied treatment. Their suicides under Oregon's assisted suicide act will be covered.⁶⁷

E. In Oregon, Other Suicides Have Increased with Legalization of Physician-Assisted Suicide

Oregon's suicide rate, which excludes suicide under Oregon's physician-assisted suicide act, is 35% higher than the national

⁶⁵ KATU TV supra.

⁶⁶ ABC News, supra.

⁶⁷ Affidavit of Kenneth Stevens, MD (Leblanc v. Attorney General) with attachments, September 18, 2012, ¶¶ 8 to 12. (Attached at A-24 to A-30).

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average.⁶⁸ This rate has been "increasing significantly since 2000."⁶⁹ Just three years prior, Oregon legalized physician-assisted suicide.⁷⁰ This increased suicide rate is consistent with a suicide contagion (legalizing one type of suicide encouraged other suicides). There is, regardless, a statistical correlation between these two events.

Montana already has one of the highest suicide rates in the nation.⁷¹ It is also a state priority to reduce this rate for persons "of all ages."⁷² Steering citizens to kill themselves is contrary to this policy.

F. Legalization of Assisted Suicide will Bring Stress, Trauma and Fear

In 2012, a study was released in Switzerland, addressing

⁶⁸ Oregon Health Authority, News Release, *Rising suicide rate in Oregon reaches higher than national average*, September 9, 2010, available at <http://www.oregon.gov/DHS/news/2010news/2010-0909a.pdf>. (Attached at A-59). See also "Suicides in Oregon: Trends and Risk Factors," Oregon Department of Human Services, Public Health Division, September 2010, page 6, ("Deaths relating to the death with Dignity Act (physician-assisted suicides) are not classified as suicides by Oregon law and therefore excluded from this report"). (Attached at A-62).

⁶⁹ Oregon Health Authority, *Rising suicide rate*. (Attached at A-59).

⁷⁰ Oregon's Annual Statistical Report for 2012, page 2 ("Since the law was passed in 1997, . . ."). (Attached at A-37, top of the page)

⁷¹ Cindy Uken, "State of Dispair: High-Country Crisis, Montana's suicide rate leads the nation," Billings Gazette, November 25, 2012, http://billingsgazette.com/news/state-and-regional/montana/montana-s-suicide-rate-leads-the-nation/article_b7b6f110-3e5c-5425-b7f6-792cc666008d.html?print=true&cid=print

⁷² 53-21-1101, MCA (regarding a required suicide reduction plan, which is to address reducing suicides by Montanans "of all ages").

trauma suffered by persons who witnessed an assisted suicide.⁷³ The study found that 1 out of 5 family members or friends present at an assisted suicide were traumatized. These persons "experienced full or sub-threshold PTSD [Post Traumatic Stress Disorder] related to the loss of a close person through assisted suicide."

Consider also the letter below by nurse Marlene Deakins, and her brother, Ron Olfert, now deceased from Sanders County. Their letter describes the "unnecessary stress" and "fear" of their brother, Wes Olfert, after he asked a question about assisted suicide in Washington State. Their letter states:

Our brother, Wes Olfert, . . . died in Washington State where assisted suicide is legal. When he was first admitted to the hospital, he made the mistake of asking for information about assisted suicide. We say a mistake, because this set off a chain of events that interfered with his care and caused him unnecessary stress in what turned out to be the last months of his life.

By asking the question, he was given a "palliative care" consult by a doctor who heavily and continually pressured him to give up on treatment before he was ready to do so. It got so bad that Wes actually became fearful of this doctor and asked us and a friend to not leave him alone with her.⁷⁴

⁷³ "Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide," B. Wagner, J. Muller, A. Maercker; European Psychiatry 27 (2012) 542-546, available at <http://choiceisanillusion.files.wordpress.com/2012/10/family-members-traumatized-eur-psych-2012.pdf> (First page attached at A-63).

⁷⁴ Ron Olfert and Marlene Deakins RN, Letter to the Board of Medical Examiners, "He made the mistake of asking for information about assisted suicide," June 29, 2012 (Attached at A-64 & A-65), available at

Kathryn Judson, in Oregon, similarly, became afraid for her husband. This was after his doctor gave him an unsolicited pitch for suicide. She states:

We got a different doctor, and David lived another five years or so. But after that nightmare in the first doctor's office, and encounters with a 'death with dignity' inclined nurse, I was afraid to leave my husband alone again with doctors and nurses, for fear they'd morph from care providers to enemies, with no one around to stop them.⁷⁵

VI. PROPOSALS FOR EXPANSION

In Washington State, where assisted suicide was legalized four years ago, there has already been a push to expand that law to direct euthanasia of non-terminal people.⁷⁶ Indeed, last March, there was a newspaper column suggesting euthanasia for people unable to afford care, which would be involuntary euthanasia.⁷⁷

<http://www.montanansagainstassistedsuicide.org/2012/06/dear-board-of-medical-examiners-we-are.html> (Accuracy confirmed by Margaret Dore, the writer of this memo, who spoke with both Ron Olfert and Marlene Deakins).

⁷⁵ Kathryn Judson, "I was afraid to leave my husband alone," Hawaii Free Press, February 15, 2011, (Attached at A-66), available at <http://www.montanansagainstassistedsuicide.org/2013/01/i-was-afraid-to-leave-my-husband-alone.html>

⁷⁶ See .e.g, Brian Faller, "Perhaps it's time to expand Washington's Death with Dignity Act," *The Olympian*, November 16, 2011, ("To improve the chances of passage, [Washington's] Death with Dignity Act was written to apply only to the choices of the terminally ill . . . This raises the question whether, if the act continues to work as intended, we should extend the choice of voluntary euthanasia to: . . . Persons who are not terminally ill . . .") Available at <http://www.theolympian.com/2011/11/16/1878667/perhaps-its-time-to-expand-washingtons.html>

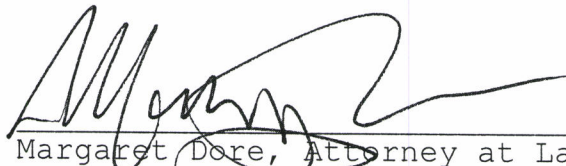
⁷⁷ See Jerry Large, "Planning for old age at a premium," *The Seattle Times*, March 8, 2012 ("After Monday's column, . . . a few [readers] suggested that if you couldn't save enough money to see you through your old age, you shouldn't

VII. CONCLUSION

SB 220's promise of patient control is an illusion. SB 220 is instead a recipe for elder abuse, especially for those with money. The most obvious gap is the lack of witnesses at the death. Even if a patient struggled, who would know?

Don't make Oregon and Washington's mistake. Reject SB 220.

Respectfully submitted February 7, 2013



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expect society to bail you out. At least a couple mentioned euthanasia as a solution.") (Emphasis added). (Attached at A-67). Available at <http://seattletimes.nwsources.com/text/2017693023.html>

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SENATE BILL NO. 220

INTRODUCED BY DICK BARRETT

A BILL FOR AN ACT ENTITLED: "AN ACT ALLOWING A TERMINALLY ILL PATIENT TO REQUEST MEDICATION TO END THE PATIENT'S LIFE; ESTABLISHING PROCEDURES; PROVIDING THE RIGHT TO RESCIND THE REQUEST; PROVIDING DEFINITIONS; PROVIDING IMMUNITY FOR PERSONS PARTICIPATING IN GOOD FAITH COMPLIANCE WITH THE PROCEDURES; PROVIDING RULEMAKING AUTHORITY; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Short title.** [Sections 1 through 20] may be cited as the "Montana Death With Dignity Act".

NEW SECTION. **Section 2. Definitions.** As used in [sections 1 through 20], the following definitions apply:

(1) "Adult" means an individual who is 18 years of age or older.

(2) "Attending physician" means the physician who has primary responsibility for the care of a patient and treatment of the patient's terminal illness.

(3) "Competent" means that, in the opinion of a court or in the opinion of a patient's attending physician, consulting physician, psychiatrist, or psychologist, the patient has the ability to make and communicate an informed decision to health care providers, including communication through a person familiar with the patient's manner of communicating if that person is available.

(4) "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding a patient's illness.

(5) "Counseling" means one or more consultations as necessary between a patient and a psychiatrist or psychologist licensed in this state for the purpose of determining that the patient is competent and is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

(6) "Department" means the department of public health and human services provided for in 2-15-2201.

(7) (a) "Health care provider" or "provider" means a person licensed, certified, or otherwise authorized

1 or permitted by law to administer health care or dispense medication in the ordinary course of business or
2 practice of a profession.

3 (b) The term includes a health care facility as defined in 50-5-101.

4 (8) "Informed decision" means a decision by a patient to request and obtain a prescription for medication
5 that the patient may self-administer to end the patient's life that is based on an understanding and
6 acknowledgment of the relevant facts and that is made after being fully informed by the attending physician of:

7 (a) the patient's medical diagnosis and prognosis;

8 (b) the potential risks associated with taking the medication to be prescribed;

9 (c) the probable result of taking the medication to be prescribed; and

10 (d) the feasible alternatives or additional treatment opportunities, including but not limited to comfort care,
11 hospice care, and pain control.

12 (9) "Medically confirmed" means the medical opinion of the attending physician has been confirmed by
13 a consulting physician who has examined the patient and the patient's relevant medical records.

14 (10) "Patient" means a person who is under the care of a physician.

15 (11) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine in this state.

16 (12) "Qualified patient" means a competent adult who is a resident of Montana and has satisfied the
17 requirements of [sections 1 through 20] in order to obtain a prescription for medication that the qualified patient
18 may self-administer to end the qualified patient's life.

19 (13) "Resident" means an individual who demonstrates residency in Montana by means that include but
20 are not limited to:

21 (a) possession of a Montana driver's license;

22 (b) proof of registration to vote in Montana;

23 (c) proof that the individual owns or leases real property in Montana; or

24 (d) filing of a Montana tax return for the most recent tax year.

25 (14) "Self-administer" means a qualified patient's act of ingesting medication to end the qualified patient's
26 life in a humane and dignified manner.

27 (15) "Terminal illness" means an incurable and irreversible illness that has been medically confirmed and
28 will, within reasonable medical judgment, result in death within 6 months.

29
30 **NEW SECTION. Section 3. Right to request medication to end life.** (1) A patient may make a written

1 request for medication to be self-administered to end the patient's life if the patient:

2 (a) is a competent adult;

3 (b) is a resident of this state;

4 (c) has been determined by the patient's attending physician and, except as provided in [section 7], by
5 a consulting physician to be suffering from a terminal illness; and

6 (d) has voluntarily expressed the wish to receive medication to end the patient's life in a humane and
7 dignified manner.

8 (2) A person may not qualify under the provisions of [sections 1 through 20] solely because of age or
9 disability.

10
11 **NEW SECTION. Section 4. Request process -- witness requirements.** (1) A patient wishing to
12 receive a prescription for medication to end the patient's life shall submit an oral request and a written request
13 to the patient's attending physician.

14 (2) A valid written request for medication under [sections 1 through 20] must be:

15 (a) in substantially the form described in [section 11];

16 (b) signed and dated by the patient; and

17 (c) witnessed by at least two individuals who, in the presence of the patient, attest that to the best of their
18 knowledge and belief the patient is:

19 (i) competent;

20 (ii) acting voluntarily; and

21 (iii) not being coerced to sign the request.

22 (3) One of the witnesses must be an individual who is not:

23 (a) related to the patient by blood, marriage, or adoption;

24 (b) at the time the request is signed, entitled to any portion of the patient's estate upon death of the
25 qualified patient under a will or any operation of law; or

26 (c) an owner, operator, or employee of a health care facility where the patient is receiving medical
27 treatment or where the patient resides.

28 (4) The patient's attending physician may not be a witness to the signing of the written request.

29 (5) If the patient is a patient in a long-term care facility, as defined in 50-5-1103, at the time the written
30 request is made, one of the witnesses must be an individual designated by the facility and who meets

1 qualifications established by the department by rule.

3 **NEW SECTION. Section 5. Right to rescind request -- requirement to offer opportunity to rescind.**

4 (1) A qualified patient may at any time rescind the qualified patient's request for medication to end the qualified
5 patient's life without regard to the qualified patient's mental state.

6 (2) A prescription for medication under [sections 1 through 20] may not be written without the attending
7 physician offering the patient an opportunity to rescind the request for medication.

9 **NEW SECTION. Section 6. Attending physician responsibilities.** (1) The attending physician shall:

10 (a) make the initial determination of whether an adult patient:

11 (i) is a resident of this state;

12 (ii) has a terminal illness;

13 (iii) is competent; and

14 (iv) has voluntarily made the request for medication pursuant to [sections 3 and 4];

15 (b) ensure that the patient is making an informed decision by discussing with the patient:

16 (i) the patient's medical diagnosis and prognosis;

17 (ii) the potential risks associated with taking the medication to be prescribed;

18 (iii) the probable result of taking the medication to be prescribed; and

19 (iv) the feasible alternatives or additional treatment opportunities, including but not limited to comfort care,
20 hospice care, and pain control;

21 (c) except as provided in [section 7], refer the patient to a consulting physician to medically confirm the
22 diagnosis and prognosis and for a determination that the patient is competent and acting voluntarily;

23 (d) if appropriate, refer the patient for counseling pursuant to [section 8];

24 (e) ensure that the patient's request does not arise from coercion or undue influence by another person;

25 (f) recommend that the patient notify the patient's next of kin;

26 (g) counsel the patient about the importance of:

27 (i) having another person present when the patient takes the medication prescribed pursuant to [sections
28 1 through 20]; and

29 (ii) not taking the medication in a public place;

30 (h) inform the patient that the patient may rescind the request for medication at any time and in any

1 manner;

2 (i) offer the patient an opportunity to rescind the request for medication before prescribing the medication;

3 (j) verify, immediately prior to writing the prescription for medication, that the patient is making an
4 informed decision;

5 (k) fulfill the medical record documentation requirements of [section 12];

6 (l) ensure that all appropriate steps are carried out in accordance with [sections 1 through 20] before
7 writing a prescription for medication to enable a qualified patient to end the qualified patient's life in a humane
8 and dignified manner; and

9 (m) (i) dispense medications directly, including ancillary medication intended to minimize the qualified
10 patient's discomfort, if the attending physician:

11 (A) is registered as a dispensing physician with the board of medical examiners provided for in
12 2-15-1731;

13 (B) has a current drug enforcement administration certificate; and

14 (C) complies with any applicable administrative rule; or

15 (ii) with the qualified patient's written consent, contact a pharmacist, inform the pharmacist of the
16 prescription, and deliver the written prescription personally or by mail to the pharmacist, who shall dispense the
17 medications to either the qualified patient, the attending physician, or a person expressly designated by the
18 qualified patient.

19 (2) Unless otherwise prohibited by law, the attending physician may sign the qualified patient's death
20 certificate.

21
22 **NEW SECTION. Section 7. Consulting physician confirmation -- waiver.** (1) Before a patient may
23 be considered a qualified patient under [sections 1 through 20], a consulting physician shall:

24 (a) examine the patient and the patient's relevant medical records;

25 (b) confirm in writing the attending physician's diagnosis that the patient is suffering from a terminal
26 illness; and

27 (c) verify that the patient:

28 (i) is competent;

29 (ii) is acting voluntarily; and

30 (iii) has made an informed decision.

(2) (a) The requirements of this section do not apply if in the attending physician's opinion the requirements would result in an undue hardship for the patient because:

(i) the patient's terminal illness is sufficiently advanced that confirmation of the illness is not necessary; or

(ii) an appointment with a consulting physician cannot be made within a reasonable amount of time or with a physician who is within a reasonable distance of the patient's residence.

(b) An attending physician who waives the requirement for a confirmation by a consulting physician shall document the reasons for the waiver in the medical documentation required pursuant to [section 12].

NEW SECTION. Section 8. Counseling referral. (1) An attending physician or a consulting physician shall refer a patient who has requested medication under [sections 1 through 20] for counseling if in the opinion of the attending physician or the consulting physician the patient may be suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

(2) Medication to end a patient's life in a humane and dignified manner may not be prescribed until the person performing the counseling determines that the patient is not suffering from a psychiatric or psychological disorder or depression causing impaired judgment.

NEW SECTION. Section 9. Informed decision required. A patient may not receive a prescription for medication to end the person's life unless the patient has made an informed decision. Immediately before writing a prescription for medication under [sections 1 through 20], the attending physician shall verify that the patient is making an informed decision.

NEW SECTION. Section 10. Family notification recommended -- not required. The attending physician shall recommend that a patient notify the patient's next of kin of the patient's request for medication pursuant to [sections 1 through 20]. A request for medication under [sections 1 through 20] may not be denied because a patient declines or is unable to notify the next of kin.

NEW SECTION. Section 11. Form of request. A request for medication as authorized by [sections 1 through 20] must be in substantially the following form:

REQUEST FOR MEDICATION TO END MY LIFE

1 IN A HUMANE AND DIGNIFIED MANNER

2 I,....., am an adult of sound mind.

3 I am suffering from, which my attending physician has determined is a terminal illness and
4 which has been medically confirmed by a consulting physician, unless my attending physician has waived the
5 confirmation requirement as provided in [section 7].6 I have been fully informed of my diagnosis and prognosis, the nature of the medication to be prescribed
7 and potential associated risks, the expected result, and the feasible alternatives or additional treatment
8 opportunities, including comfort care, hospice care, and pain control.9 I request that my attending physician prescribe medication that will end my life in a humane and dignified
10 manner and authorize my attending physician to contact any pharmacist about my request.

11 INITIAL ONE:

12I have informed my family of my decision and taken their opinions into consideration.

13I have decided not to inform my family of my decision.

14I have no family to inform of my decision.

15 I understand that I have the right to rescind this request at any time.

16 I understand the full import of this request, and I expect to die when I take the medication to be
17 prescribed. I further understand that although most deaths occur within 3 hours, my death may take longer, and
18 my attending physician has counseled me about this possibility.19 I make this request voluntarily and without reservation, and I accept full moral responsibility for my
20 actions.

21 Signed:.....

22 Dated:.....

23 DECLARATION OF WITNESSES

24 We declare that the person signing this request:

25 (a) is personally known to us or has provided proof of identity;

26 (b) signed this request in our presence;

27 (c) appears to be of sound mind and not under duress, fraud, or undue influence; and

28 (d) is not a patient for whom either of us is the attending physician.

29Witness 1/Date

30Witness 2/Date

NOTE: One witness may not be a relative (by blood, marriage, or adoption) of the person signing this request, may not be entitled to any portion of the person's estate upon death, and may not own, operate, or be employed at a health care facility where the person is a patient or where the person resides. If the patient is an inpatient at a health care facility, one of the witnesses must be an individual designated by the facility.

NEWSECTION. Section 12. Medical record documentation requirements. The following items must be documented or filed in the patient's medical record:

(1) the determination and the basis for determining that a patient requesting medication to end the patient's life in a humane and dignified manner is a qualified patient;

(2) all oral requests by a patient for medication made pursuant to [section 4] to end the patient's life in a humane and dignified manner;

(3) all written requests by a patient for medication made pursuant to [sections 3 and 4] to end the patient's life in a humane and dignified manner;

(4) the attending physician's diagnosis, prognosis, and determination that the patient is competent, is acting voluntarily, and has made an informed decision;

(5) unless waived as provided in [section 7], the consulting physician's diagnosis, prognosis, and verification that the patient is competent, is acting voluntarily, and has made an informed decision;

(6) the reasons for waiver of confirmation by a consulting physician, if a waiver was made;

(7) a report of the outcome and determinations made during counseling, if performed;

(8) the attending physician's offer before prescribing the medication to allow the patient to rescind the patient's request for the medication; and

(9) a note by the attending physician indicating:

(a) that all requirements under [sections 1 through 20] have been met; and

(b) the steps taken to carry out the request, including a notation of the medication prescribed.

NEWSECTION. Section 13. Effect on construction of wills, contracts, and statutes. (1) A provision in a contract, will, or other agreement, whether written or oral, to the extent the provision would affect whether a person may make or rescind a request for medication to end the person's life in a humane and dignified manner is not valid.

(2) An obligation owing under any currently existing contract may not be conditioned or affected by a

1 person making or rescinding a request for medication to end the person's life in a humane and dignified manner.

2
3 **NEW SECTION. Section 14. Insurance or annuity policies.** (1) The sale, procurement, or issuance
4 of a life, health, or accident insurance or annuity policy or the rate charged for a policy may not be conditioned
5 upon or affected by a person making or rescinding a request for medication to end the person's life in a humane
6 and dignified manner.

7 (2) A qualified patient's act of ingesting medication to end the qualified patient's life in a humane and
8 dignified manner may not have an effect upon a life, health, or accident insurance or annuity policy.

9
10 **NEW SECTION. Section 15. Immunities -- prohibitions on certain health care providers --**
11 **notification -- permissible sanctions.** (1) A person is not subject to civil or criminal liability or professional
12 disciplinary action for participating in good faith compliance with [sections 1 through 20], including an individual
13 who is present when a qualified patient takes the prescribed medication to end the qualified patient's life in a
14 humane and dignified manner.

15 (2) A health care provider or professional organization or association may not subject an individual to
16 censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for
17 participating or refusing to participate in good faith compliance with [sections 1 through 20].

18 (3) A request by a patient for or provision by an attending physician of medication in good faith
19 compliance with the provisions of [sections 1 through 20] does not constitute neglect for any purpose of law or
20 provide the sole basis for the appointment of a guardian or conservator.

21 (4) (a) A health care provider may choose whether to participate in providing to a qualified patient any
22 medication to end the patient's life in a humane and dignified manner and is not under any duty, whether by
23 contract, by statute, or by any other legal requirement, to participate in providing a qualified patient with the
24 medication.

25 (b) If a health care provider is unable or unwilling to carry out a patient's request under [sections 1
26 through 20] and the patient transfers care to a new health care provider, the prior health care provider shall
27 transfer, upon request, a copy of the patient's relevant medical records to the new health care provider.

28 (5) (a) Unless otherwise required by law, a health care provider may prohibit another health care provider
29 from participating in activities under [sections 1 through 20] on the premises of the prohibiting provider if the
30 prohibiting provider has notified the health care provider in writing of the prohibiting provider's policy against

1 participating in activities under [sections 1 through 20]. Nothing in this subsection (5) prevents a health care
2 provider from providing a patient with health care services that do not constitute participation in activities under
3 [sections 1 through 20].

4 (b) Notwithstanding the provisions of subsections (1) through (4), a health care provider may subject
5 another health care provider to the following sanctions if the sanctioning health care provider has notified the
6 sanctioned provider prior to participation in activities under [sections 1 through 20] that the sanctioning provider
7 prohibits participation in activities under [sections 1 through 20]:

8 (i) loss of privileges, loss of membership, or any other sanction provided pursuant to the medical staff
9 bylaws, policies, and procedures of the sanctioning health care provider if the sanctioned provider is a member
10 of the sanctioning provider's medical staff and is participating in activities under [sections 1 through 20] while on
11 the health care facility premises of the sanctioning health care provider, but not including the private medical
12 office of a physician or other provider;

13 (ii) termination of lease or other property contract or other nonmonetary remedies provided by lease
14 contract, not including loss or restriction of medical staff privileges or exclusion from a provider panel, if the
15 sanctioned provider participates in activities under [sections 1 through 20] while on the premises of the
16 sanctioning health care provider or on property that is owned by or under the direct control of the sanctioning
17 health care provider; or

18 (iii) termination of contract or other nonmonetary remedies provided by contract if the sanctioned provider
19 participates in activities under [sections 1 through 20] while acting in the course and scope of the sanctioned
20 provider's capacity as an employee or independent contractor of the sanctioning health care provider.

21 (c) The provisions of subsection (5)(b) may not be construed to prevent:

22 (i) a health care provider from participating in activities under [sections 1 through 20] while acting outside
23 the course and scope of the provider's capacity as an employee or independent contractor; or

24 (ii) a patient from contracting with the patient's attending physician and consulting physician to act outside
25 the course and scope of the provider's capacity as an employee or independent contractor of the sanctioning
26 health care provider.

27 (d) A health care provider that imposes sanctions pursuant to subsection (5)(b) shall follow all due
28 process and other established procedures of the sanctioning health care provider that are related to the
29 imposition of sanctions on any other health care provider.

30 (6) For purposes of this section, "participating in activities under [sections 1 through 20]" means to

1 perform:

2 (a) the duties of an attending physician pursuant to [section 6];

3 (b) the duties of a consulting physician pursuant to [section 7]; or

4 (c) the counseling function pursuant to [section 8].

5 (7) Suspension or termination of staff membership or privileges under subsection (5) is not reportable
6 to a licensing board provided for in Title 37. Action taken pursuant to [section 4, 6, 7, or 8] may not be the sole
7 basis for a report of unprofessional conduct under 37-1-308.

8 (8) A provision of [sections 1 through 20] may not be construed to allow a lower standard of care for
9 patients in the community where the patient is treated or in a similar community.

10

11 **NEW SECTION. Section 16. Nonsanctionable activities.** A health care provider may not be
12 sanctioned under [section 15] for:

13 (1) making an initial determination that a patient has a terminal illness and informing the patient of the
14 medical prognosis;

15 (2) providing information about the Montana Death With Dignity Act to a patient upon the request of the
16 patient;

17 (3) providing a patient, upon the request of the patient, with a referral to another physician; or

18 (4) contracting with a patient to act outside the course and scope of the provider's capacity as an
19 employee or independent contractor of a health care provider that prohibits activities under [sections 1 through
20 20].

21

22 **NEW SECTION. Section 17. Liabilities.** (1) Purposely or knowingly altering or forging a request for
23 medication to end a patient's life without the authorization of the patient or concealing or destroying a rescission
24 of a request for medication is punishable as a felony if the act is done with the intent or effect of causing the
25 patient's death.

26 (2) Purposely or knowingly coercing or exerting undue influence on a patient to request medication for
27 the purpose of ending the patient's life or to destroy a rescission of a request is punishable as a felony.

28 (3) Nothing in [sections 1 through 20] limits further liability for civil damages resulting from other negligent
29 conduct or intentional misconduct by any person.

30 (4) The penalties in [sections 1 through 20] do not preclude criminal penalties applicable under other law

1 for conduct inconsistent with the provisions of [sections 1 through 20].

2 (5) For purposes of this section, "purposely" and "knowingly" have the meaning provided in 45-2-101.

3
4 **NEW SECTION. Section 18. Penalties.** (1) It is a felony for a person without the authorization of the
5 patient to purposely or knowingly alter, forge, conceal, or destroy an instrument, the reinstatement or revocation
6 of an instrument, or any other evidence or document reflecting the patient's desires and interests with the intent
7 and effect of causing a withholding or withdrawal of life-sustaining procedures or of artificially administered
8 nutrition and hydration that hastens the death of the patient.

9 (2) Except as provided in subsection (1), it is a misdemeanor for a person without authorization of the
10 patient to purposely or knowingly alter, forge, conceal, or destroy an instrument, the reinstatement or revocation
11 of an instrument, or any other evidence or document reflecting the patient's desires and interests with the intent
12 or effect of affecting a health care decision.

13 (3) For purposes of this section, "purposely" and "knowingly" have the meaning provided in 45-2-101.

14
15 **NEW SECTION. Section 19. Claims by governmental entity for costs incurred.** A governmental
16 entity that incurs costs resulting from a qualified patient terminating the qualified patient's life in a public place
17 while acting pursuant to [sections 1 through 20] may submit a claim against the estate of the person to recover
18 costs and reasonable attorney fees related to enforcing the claim.

19
20 **NEW SECTION. Section 20. Construction.** Nothing in [sections 1 through 20] may be construed to
21 authorize a physician or any other person to end a patient's life by lethal injection, mercy killing, or active
22 euthanasia. Actions taken in accordance with [sections 1 through 20] may not for any purposes constitute suicide,
23 assisted suicide, mercy killing, or homicide under the law.

24
25 **NEW SECTION. Section 21. Codification instruction.** [Sections 1 through 20] are intended to be
26 codified as an integral part of Title 50, and the provisions of Title 50 apply to [sections 1 through 20].

27
28 **NEW SECTION. Section 22. Severability.** If a part of [this act] is invalid, all valid parts that are
29 severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications,
30 the part remains in effect in all valid applications that are severable from the invalid applications.

1

2 NEW SECTION. **Section 23. Effective date.** [This act] is effective on passage and approval.

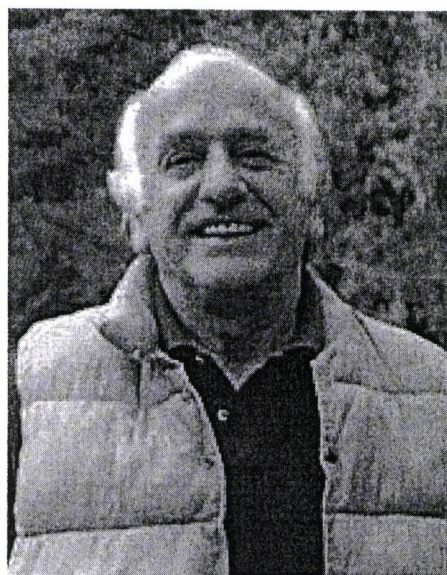
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X Derek Humphry to be Keynote Speaker at 2011 Annual Meeting



This year our keynote speaker will be Derek Humphry, the author of *Final Exit* and the founder of the Hemlock Society USA in 1980. Derek is generally considered to be the father of the modern movement for choice at the end of life in America.

Save the Date!
Sat., October 22, 2011, 1-3 p.m.
University Unitarian Church
6556 35th Ave NE
Seattle, WA 98115-7393

Derek is a British journalist and author who has lived in the United States since 1978, the same year he published the book *Jean's Way* describing his first wife's final years of suffering from cancer and his part in helping her to die peacefully. The public response to the book caused him to start the Hemlock Society USA in 1980 from his garage in Santa Monica. Years later, the Hemlock Society would become End of Life Choices and then merge with Compassion In Dying to become Compassion & Choices.

In 1991 he published *Final Exit*. Much to his surprise, it became the national #1 bestseller within six months. Since then it has been translated into 12 languages and is now in its fourth edition.

Although not affiliated with – and sometimes even at odds with – Compassion & Choices, Derek is still actively involved in the movement. Always interesting and sometimes controversial, Derek will provide our supporters and their guests with his perspective about the evolution of the movement for choice at the end of life in America.

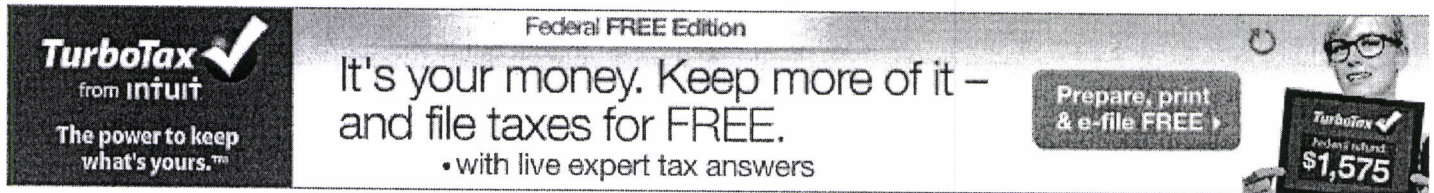
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Published: Sunday, March 20, 2011, midnight PDT

SUICIDE KITS SELL DEATH BY MAIL

Legislation is being prepared to outlaw sale of helium hoods

By Randi Bjornstad

The Register-Guard

Appeared in print: Sunday, March 20, 2011, page A1

His mind was keen, his grin infectious. His passions were politics and sports. He read voraciously. His humor was prankish, his wit razor-sharp.

Born and raised in Eugene, he adored his parents and four brothers. He graduated from South Eugene High School and the University of Michigan.

For years, he struggled through bouts of pain and fatigue that defied medical diagnosis and left him depressed about his inability to carry on normal daily activities and fearful that he would never regain normal health.

A-15

He had dreams, ambitions, accomplishments and, say many who knew him, vast potential.

But three months ago, in the throes of a flu that upended a period of relatively good health, Nick Klonoski took his own life.

He had just turned 29.

Klonoski did not use any of the commonly known methods of suicide. Instead, he employed a "helium hood kit" that he ordered by mail from a two-person company in Southern California.

The small, white box, measuring 10 by 7 by 3 inches and decorated with a butterfly, holds a brown paper packet, its edges zigzagged with pinking shears and stitched shut on a sewing machine. Inside the packet is a clear plastic bag with an elasticized band sewn to the open end, to slip over the head and fit snugly around the neck. The box also contains clear plastic tubing, for hooking up tanks of lethal helium gas.

Manufactured and sold by The Gladd Group, the helium hood kit has no other use than to assist a person contemplating suicide. It costs \$60, payable only by cash or check. According to Manta, an online business networking site where small-business owners can share information, The Gladd Group has two employees and estimated annual sales of \$98,000 — equal to the price of 1,633 kits.

Selling a "suicide kit" — coupled with detailed instructions from another right-to-suicide organization on where to buy it and how to use it — raises complex legal, ethical and emotional questions about what constitutes helping another person to take his or her own life. Assisting another person's suicide violates the law in most states, including Oregon. But definitions of aiding, promoting, encouraging or assisting are not legally precise.

No one to date has been prosecuted for selling a helium hood kit in the United States. Many police agencies, medical examiners, district attorneys and legislators know little or nothing about the kits, although now that he is aware of them, state Sen. Floyd Prozanski, D-Eugene, says he's drafting a bill to outlaw their sale.

The right-to-suicide movement argues that disseminating how-to information about suicide and selling the kits that facilitate the act are protected by the free speech clause of the First Amendment in the U.S. Constitution.

On the afternoon he died, Klonoski drove to a party goods store not far from his family's Eugene home. A store receipt police found in his room shows that at 2:16 p.m., he signed for rental of a large tank of helium. Returning home, with the rest of his family out of the house for the afternoon — all five brothers had gathered at the family home for the holidays — he followed the instructions for using the helium hood kit as detailed in "Final Exit," a book written by longtime pro-suicide activist and longtime Lane County resident, Derek Humphry. He died in his bedroom before his family returned.

Jake Klonoski, at 30 the oldest of the Klonoski brothers, found his next-younger brother's body after Nick didn't respond to attempts to call him to dinner.

"I know Nick was vulnerable because of the health issues he had been dealing with for years, but he wasn't terminally ill, and he seemed to have been getting better until the flu thing happened," Jake Klonoski said. "He had family and many friends to help him through the bad times and then enjoy the good times with him. Now I know there also are people out there ready to persuade people like Nick to give up."

Nearly 1,000 people, including a former governor and a busload of colleagues from one of his many political projects, packed Temple Beth Israel's huge sanctuary — the only place large enough to accommodate the crowd on a cold sunny afternoon in early January — to honor Nick Klonoski's life. Although the family is

not Jewish, his brothers wore yarmulkes, bright yellow imprinted with the blue emblem of the University of Michigan, in his honor. Speakers laughed and cried as they chronicled his intellectual brilliance and mischievous nature, and mourned the loss of his immense possibilities.

Overwhelmed by his death, his mother, U.S. District Court Judge Ann Aiken, declines to speak publicly about it. His father, retired University of Oregon political science professor James Klonoski, died two years ago. But two of his brothers, Jake and Zach Klonoski, are determined to speak out, to stop what they consider illegal and immoral assisted suicide.

"The company that sells this kit obviously is purposely targeting a vulnerable group," said Jake Klonoski, a law student at Stanford University. "They made money off my brother, they gave him the tools to take his own life without knowing him, without knowing anything about him. For \$60, they blew his life apart. It breaks my heart."

When it comes to promoting an American's right to die by suicide, all roads lead to Derek Humphry. He describes himself in an online autobiography as "a journalist and author who has spent the last 30 years campaigning for lawful physician-assisted dying to be an option for the terminally and hopelessly ill." X

His first book, "Jean's Way," tells of his first wife's suicide in 1975 — with his assistance, by his acknowledgement — when she was terminally ill with bone cancer. In 1980, he founded the Hemlock Society to help change laws prohibiting assisted suicide as well as share information about suicide methods.

More books followed. The royalties allowed the organization to provide substantial financial backing to initiative campaigns in favor of physician-assisted suicide — unsuccessful in California and Washington and successful in Oregon — in the late 1980s and early '90s. Since then, Washington and Montana voters have joined Oregon in allowing physician-assisted suicide.

In February 1991, Humphry published "Final Exit: The Practicalities of Self-Deliverance and Assisted Suicide for the Dying," his best-known book.

"It sold 500,000 copies in its first six weeks — I was staggered," Humphry said in a recent telephone interview. "It has been translated into 12 languages, and it has sold well over a million copies. It doesn't sell hugely now, but it is consistent. It has made me a living, and it has funded my organizations considerably."

In 1992, "temporarily burned out," British-born Humphry abandoned the Hemlock Society, but the next year he formed a new organization, ERGO — Euthanasia Research & Guidance Organization — to continue his quest. His goal expanded to making assisted suicide legal not only to the terminally or "hopelessly" ill, as he puts it, but to anyone who seeks it, except "the mentally disturbed, including the depressed, (or) for the disabled or the handicapped."

Humphry also formed NuTech — New Technology for Self-Deliverance Group — to find new ways to help "adults who do not qualify under (assisted suicide) law but their illness still justifies, to them, bringing life to an end." The group's mission, Humphry wrote, was "to explore methods of hastened death that dying persons could use to 'self-deliver' without breaking the law or with help from a physician."

The helium hood kit emerged as the group's "chief success," Humphry wrote, allowing "a peaceful, quick death in minutes."

The third edition of "Final Exit," and an addendum published in 2009, provide detailed instructions on how to use the helium hood kit for "self-deliverance," including how to rent helium tanks without exciting suspicion. Humphry also has made a DVD of the process, in which he demonstrates use of the kit. He makes





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Terminal Uncertainty

Washington's new "Death With Dignity" law allows doctors to help people commit suicide—once they've determined that the patient has only six months to live. But what if they're wrong?

By Nina Shapiro

published: January 14, 2009

Nina Shapiro



Maryanne Clayton with her son, Eric, in the Fred Hutch waiting room: "I just kept going."

Details:

- Study: [Why Now?](#) Timing and Circumstances of Hastened Deaths
- [Dilemmas by caretakers](#) and other Oregon studies
- [Stats on people](#) who have used Oregon's Death with Dignity law.
- [Harvard professor Nicholas Christakis](#) looking at the accuracy of prognosis.
- [JAMA study](#) examining the accuracy of prognosis.

UPDATE: ["It Felt Like the Big One"](#)

She noticed the back pain first. Driving to the grocery store, Maryanne Clayton would have to pull over to the side of the road in tears. Then 62, a retired computer technician, she went to see a doctor in the Tri-Cities, where she lived. The diagnosis was grim. She already had Stage IV lung cancer, the most advanced form there is. Her tumor had metastasized up her spine. The doctor gave Clayton two to four months to live.

That was almost four years ago.

Prodded by a son who lives in Seattle, Clayton sought treatment from Dr. Renato Martins, a lung cancer specialist at Fred Hutchinson Cancer Research Center. Too weak to endure the toxicity of chemotherapy, she started with radiation, which at first made her even weaker but eventually built her strength. Given dodgy prospects with the standard treatments, Clayton then decided to participate in the clinical trial of a new drug called pemetrexate.

Her response was remarkable. The tumors shrunk, and although they eventually grew back, they shrunk again when she enrolled in a second clinical trial. (Pemetrexate has since been approved by the FDA for initial treatment in lung cancer cases.) She now comes to the Hutch every three weeks to see Martins, get CT scans, and undergo her drug regimen. The prognosis she was given has proved to be "quite wrong."

"I just kept going and going," says Clayton. "You kind of don't notice how long it's been." She is a plain-spoken woman with a raspy voice, a pink face, and grayish-brown hair that fell out during treatment but grew back newly lustrous. "I had to have cancer to have nice hair," she deadpans, putting a hand to her short tresses as she sits, one day last month, in a Fred Hutchinson waiting room. Since the day she was given two to four months to live, Clayton has gone with her children on a series of vacations, including a cruise to the Caribbean, a trip

to Hawaii, and a tour of the Southwest that culminated in a visit to the Grand Canyon. There she rode a hot-air balloon that hit a snag as it descended and tipped over, sending everybody crawling out.

"We almost lost her because she was having too much fun, not from cancer," Martins chuckles.

Her experience underscores the difficulty doctors have in forecasting how long patients have to live—a difficulty that is about to become even more pertinent as the Washington Death With Dignity Act takes effect March 4. The law, passed by initiative last November and modeled closely on a 14-year-old law in Oregon, makes Washington the only other state in the country to allow terminally ill patients to obtain lethal medication. As in Oregon, the law is tightly linked to a prognosis: Two doctors must say a patient has six months or less to live before such medication can be prescribed.

The law has deeply divided doctors, with some loath to help patients end their lives and others asserting it's the most humane thing to do. But there's one thing many on both sides can agree on. Dr. Stuart Farber, head of palliative care at the University of Washington Medical Center, puts it this way: "Our ability to predict what will happen to you in the next six months sucks."

In one sense, six months is an arbitrary figure. "Why not four months? Why not eight months?" asks Arthur Caplan, director of the Center for Bioethics at the University of Pennsylvania, adding that medical literature does not define the term "terminally ill." The federal Medicare program, however, has determined that it will pay for hospice care for patients with a prognosis of six months or less. "That's why we chose six months," explains George Eighmey, executive director of Compassion & Choices of Oregon, the group that led the advocacy for the nation's first physician-assisted suicide law. He points out that doctors are already used to making that determination.

To do so, doctors fill out a detailed checklist derived from Medicare guidelines that are intended to ensure that patients truly are at death's door, and that the federal government won't be shelling out for hospice care indefinitely. The checklist covers a patient's ability to speak, walk, and smile, in addition to technical criteria specific to a person's medical condition, such as distant metastases in the case of cancer or a "CD4 count" of less than 25 cells in the case of AIDS.

No such detailed checklist is likely to be required for patients looking to end their lives in Washington, however. The state Department of Health, currently drafting regulations to comply with the new law, has released a preliminary version of the form that will go to doctors. Virtually identical to the one used in Oregon, it simply asks doctors to check a box indicating they have determined that "the patient has six months or less to live" without any additional questions about how that determination was made.

Even when applying the rigid criteria for hospice eligibility, doctors often get it wrong, according to Nicholas Christakis, a professor of medicine and sociology at Harvard University and a pioneer in research on this subject. As a child, his mother was diagnosed with Hodgkin's disease. "When I was six, she was given a 10 percent chance of living beyond three weeks," he writes in his 2000 book, *Death Foretold: Prophecy and Prognosis in Medical Care*. "She lived for nineteen remarkable years...I spent my boyhood always fearing that her lifelong chemotherapy would stop working, constantly wondering whether my mother would live or die, and both craving and detesting prognostic precision."

Sadly, Christakis' research has shown that his mother was an exception. In 2000, Christakis published a study in the *British Medical Journal* that followed 500 patients admitted to hospice programs in Chicago. He found that only 20 percent of the patients died approximately when their doctors had predicted. Unfortunately, most died *sooner*. "By and large, the physicians were overly optimistic," says Christakis.

In the world of hospice care, this finding is disturbing because it indicates that many patients aren't being referred early enough to take full advantage of services that might ease their final months. "That's what has frustrated hospices for decades," says Wayne McCormick, medical director of Providence Hospice of Seattle, explaining that hospice staff frequently don't get enough time with patients to do their best work.

Death With Dignity advocates, however, point to this finding to allay concerns that people might be killing themselves too soon based on an erroneous six-month prognosis. "Of course, there is the occasional person who outlives his or her prognosis," says Robb Miller, executive director of Compassion & Choices of Washington. Actually, 17 percent of patients did so in the Christakis study. This roughly coincides with data collected by the National Hospice and Palliative Care Organization, which in 2007 showed that 13 percent of hospice patients around the country outlived their six-month prognoses.

It's not that prognostication is completely lacking in a scientific basis. There is a reason that you can pick up a textbook and find a life expectancy associated with most medical conditions: Studies have followed *populations* of people with these conditions. It's a statistical average. To be precise, it's a median, explains Martins. "That means 50 percent will do worse and 50 percent will do better."

Doctors also shade their prognoses according to their own biases and desires. Christakis' study found that the longer a doctor knew a patient, the more likely their prognosis was inaccurate, suggesting that doctors who get attached to their patients are reluctant to talk of their imminent demise. What's more, Christakis says, doctors see death "as a mark of failure."

Oncologists in particular tend to adopt a cheerleading attitude "right up to the end," says Brian Wicks, an orthopedic surgeon and past president of the Washington State Medical Association. Rather than talk about death, he says, their attitude is "Hey, one more round of chemo!"

But it is also true that one more round of chemo, or new drugs like the one that helped Clayton, or sometimes even just leaving patients alone, can help them in ways that are impossible to predict. J. Randall Curtis, a pulmonary disease specialist and director of an end-of-life research program at Harborview Medical Center, recalls treating an older man with severe emphysema a couple of years ago. "I didn't think I could get him off life support," Curtis says. The man was on a ventilator. Every day Randall tested whether the patient could breathe on his own, and every day the patient failed the test. He had previously made it clear that he did not want to be kept alive by machines, according to Curtis, and so the doctor and the man's family made the wrenching decision to pull the plug.

But instead of dying as expected, the man slowly began to get better. Curtis doesn't know exactly why, but guesses that for that patient, "being off the ventilator was probably better than being on it. He was more comfortable, less stressed." Curtis says the man lived for at least a year afterwards.

Curtis also once kept a patient on life support against his better judgment because her family insisted. "I thought she would live days to weeks," he says of the woman, who was suffering from septic shock and multiple organ failure. Instead she improved enough to eventually leave the hospital and come back for a visit some six or eight months later.

"It was humbling," he says. "It was not amazing. That's the kind of thing in medicine that happens frequently."

Every morning when Heidi Mayer wakes up, at 5 a.m. as is her habit, she says "Howdy" to her husband Bud—very loudly. "If he says 'Howdy' back, I know he's OK," she explains.

"There's always a little triumph," Bud chimes in. "I made it for another day."

It's been like this for years. A decade ago, after clearing a jungle of blackberries off a lot he had bought adjacent to his secluded ranch house south of Tacoma, Bud came down with a case of pneumonia. "Well, no wonder he's so sick," Heidi recalls the chief of medicine saying at the hospital where he was brought. "He's in congestive heart failure."

Then 75, "he became old almost overnight," Heidi says. Still, Bud was put on medications that kept him going—long enough to have a stroke five years later, kidney failure the year after that, and then the onset of severe chest pain known as angina. "It was scary," says Heidi, who found herself struggling at 3 a.m. to find Bud's veins so she could inject the morphine that the doctor had given Bud for the pain. Heidi is a petite blond nurse with a raucous laugh. She's 20 years younger than her husband, whom she met at a military hospital, and shares his cigar-smoking habit. Bud was a high-flying psychiatrist in the '80s when he became the U.S. Assistant Secretary of Defense, responsible for all Armed Forces health activities.

After his onslaught of illnesses, Bud says, his own prognosis for himself was grim. "Looking at a patient who had what I had, I would have been absolutely convinced that my chance of surviving more than a few months was very slim indeed."

Bud's doctor eventually agreed, referring him to hospice with a prognosis of six months. That was a year and a half ago. Bud, who receives visits from hospice staff at home, has since not gotten much worse or much better. Although he has trouble walking and freely speaks of himself as "dying," he looks like any elderly grandfather, sitting in a living room decorated with mounted animal heads, stuffing tobacco into his pipe and chatting about his renewed love of nature and the letter he plans to write to Barack Obama with his ideas for improving medical care. Despite his ill health, he says the past few years have been a wonderful, peaceful period for him—one that physician-assisted suicide, which he opposes, would have cut short.

A year after he first began getting visits from the Franciscan Hospice, the organization sent Dr. Bruce Brazina to Mayer's home to certify that he was still really dying. It's something Brazina says he does two to four times a week as patients outlive their six-month prognoses. Sometimes, Brazina says, patients have improved so much he can no longer forecast their imminent death. In those cases, "we take them off service"—a polite way of saying that patients are kicked off hospice care, a standard procedure at all hospices due to Medicare rules. But Brazina found that Mayer's heart condition was still severe enough to warrant another six-month prognosis, which the retired doctor has just about outlived again.

"It's getting to the point where I'm a little embarrassed," Mayer says.

What's going on with him is a little different than what happened to Randall Curtis' patients or to Maryanne Clayton. Rather than reviving from near death or surviving a disease that normally kills quickly, Mayer is suffering from chronic diseases that typically follow an unpredictable course. "People can be very sick but go along fine and stable," Brazina explains. "But then they'll have an acute attack." The problem for prognosis is that doctors have no way of knowing when those attacks will be or whether patients will be able to survive them.

When a group of researchers looked specifically at patients with three chronic conditions—pulmonary disease, heart failure, and severe liver disease—they found that many more people outlived their prognosis than in the Christakis study. Fully 70 percent of the 900 patients eligible for hospice care lived longer than six months, according to a 1999 paper published in the *Journal of the American Medical Association*.

Given these two studies, it's no surprise that in Oregon some people who got a prescription for lethal medication on the basis of a six-month prognosis have lived longer. Of the 341 people who put themselves to death as of 2007 (the latest statistics available), 17 did so between six months and two years after getting their prescription, according to state epidemiologist Katrina Hedberg. Of course, there's no telling how long any of the 341 would have lived had they not killed themselves. The Department of Health does not record how long people have lived after getting prescriptions they do not use, so there's no telling, either, whether those 200 people outlived their prognosis. Compassion & Choices of Oregon, which independently keeps data on the people whom it helps navigate the law, says some have lived as long as eight years after first inquiring about the process (although it doesn't track whether they ever received the medication and a six-month prognosis).

The medical field's spotty track record with prognosis is one reason Harborview's Curtis says he is not comfortable participating in physician-assisted suicide. It's one thing to make a six-month prognosis that will allow patients access to hospice services, he says, and quite another to do so for the purpose of enabling patients to kill themselves. "The consequences of being wrong are pretty different," he says.

Under the law, doctors and institutions are free to opt out, and several Catholic institutions like Providence Hospice of Seattle have already said they will do so. Medical director McCormick finds the idea of patients killing themselves particularly troubling because "you can't predict what's going to happen or who's going to show up near the end of your life." He says he has watched people make peace with loved ones or form wonderful new connections. He's preparing a speech in case patients ask about the new law: "I will stop at nothing to ensure that you're comfortable. I won't shorten your life, but I will make it as high-quality as possible."

Thomas Preston, a retired cardiologist who serves as medical director of Compassion & Choices of Washington, says he has in mind a different kind of speech: "You have to understand that this prognosis could be wrong. You may have more than six months to live. You may be cutting off some useful life."

He also says he will advise doctors to be more conservative than the law allows. "If you think it's going to be six months, hold off on it [writing a prescription]—just to be sure." Instead, he'll suggest that doctors wait until they think a patient has only one or two months to live.

The UW's Farber leans toward a different approach. While he says he hasn't yet decided whether he himself will write fatal prescriptions, he plans at least to refer patients to others who will. Given that prognostic precision is impossible, he says, "I personally just let go of the six months." Instead, he says he would try to meet what he sees as the "spirit of the law" by assessing that someone is "near" the end of their life, so that he could say to them, "You're really sick and you're not going to get better."

Knowing exactly when someone is going to die, he continues, is not as important as knowing when someone "has reached the point where their life is filled with so much suffering that they don't want to be alive."

Randy Niedzielski reached that point in the summer of 2006, according to his wife Nancy. Diagnosed with brain cancer in 2000, the onetime Lynnwood property manager had been through several rounds of chemotherapy and had lived years longer than the norm. But the cancer cells had come back in an even more virulent form and had spread to his muscle system. "He would have these bizarre muscle contractions," Nancy recalls. "His feet would go into a cone shape. His arms would twist in weird angles." Or his chest would of its own volition go into what Nancy calls a "tent position," rising up from his arms. "He'd just be screaming in pain."

Randy would have liked to move to Oregon to take advantage of the Death With Dignity Act there, according to Nancy. But he didn't have time to establish residency as required. That was about six weeks before his death.

Nancy, who has become an advocate for physician-assisted suicide, says that typically people are only weeks or days away from death when they want to kill themselves. Oregon's experience with people hanging onto their medicine for so long, rather than rushing to use it as soon as they get a six-month prognosis, bears this out, she says: "A patient will know when he's at the very end of his life. Doctors don't need to tell you."

Sometimes, though, patients are not so near the end of their life when they're ready to die. University of Washington bioethics professor Helene Starks and Anthony Back, director of palliative care at the Seattle Cancer Care Alliance, are two of several researchers who in 2005 published a study that looked at 26 patients who "hastened" their death. A few were in Oregon, but most were in Washington, and they brought about their own demise mostly either by refusing to eat or drink or by obtaining medication illegally, according to Back and Starks. Three of these patients had "well over six months" of remaining life, Starks says, perhaps even years.

The paper, published in the *Journal of Pain and Symptom Management*, quotes from an interview with one of these patients before she took her life. Suffering from a congenital malformation of the spine, she said it had reached the point that her spine or neck could be injured even while sitting. "I'm in an invisible prison," she continued. "Every move I make is an effort. I can't live like this because of the constant stress, unbearable pain, and the knowledge that it will never be any better."

Under the law, she would not be eligible for lethal medication. Her case was not considered "terminal," according to the paper. But for patients like her, the present is still unbearable. Former governor Booth Gardner, the state's most visible champion of physician-assisted suicide, would have preferred a law that applied to everyone who viewed their suffering this way, regardless of how long they were expected to live. He told *The New York Times Magazine*, for a December 2007 story, that the six-month rule was a compromise meant to help insure the passage of Initiative 1000. Gardner has Parkinson's disease, and now can talk only haltingly by phone. In an interview he explained that he has been housebound of late due to several accidents related to his lack of balance.

Researchers who have interviewed patients, their families, and their doctors have found, however, that pain is not the central issue. Fear of future suffering looms larger, as does people's desire to control their own end.

"It comes down to more existential issues," says Back. For his study of Washington and Oregon patients, he interviewed one woman who had been a successful business owner. "That's what gave her her zest for life," Back says, and without it she was ready to die.

Maryanne Clayton says she has never reached that point. Still, she voted for the Death With Dignity Act. "Why force me to suffer?" she asks, adding that if she were today in as much pain as she was when first diagnosed with lung cancer, she might consider taking advantage of the new law. But for now, she still enjoys life. Her 35-year-old son Eric shares a duplex with her in the Tri-Cities. They like different food. But every night he cooks dinner on his side, she cooks dinner on her side, and they eat together. And one more day passes that proves her prognosis wrong.

nshapiro@seattleweekly.com

CANADA

C O U R S U P É R I E U R E

PROVINCE DE QUÉBEC

DISTRICT DE TROIS-RIVIÈRES

No. : 400-17-002642-110

GINETTE LEBLANC,
demanderesse

c.

PROCUREUR GÉNÉRAL DU CANADA,
défendeur

et

PROCUREUR GÉNÉRAL DU QUÉBEC,
mis-en-cause

AFFIDAVIT OF KENNETH R. STEVENS, JR., MD

THE UNDERSIGNED, being duly sworn under oath, states:

1. I am a doctor in Oregon USA where physician-assisted suicide is legal. I am also a Professor Emeritus and a former Chair of the Department of Radiation Oncology, Oregon Health & Science University, Portland, Oregon. I have treated thousands of patients with cancer.
2. In Oregon, our assisted suicide law applies to patients predicted to have less than six months to live. I write to clarify for the court that this does not necessarily mean that patients are dying.
3. In 2000, I had a cancer patient named Jeanette Hall. Another doctor had given her a terminal diagnosis of six months to a year to live, which was based on her not being treated for cancer. I understand that he had referred her to me.

4. At our first meeting, Jeanette told me plainly that she did not want to be treated and that was going to "do" our law, i.e., kill herself with a lethal dose of barbiturates. It was very much a settled decision.

5. I, personally, did not and do not believe in assisted suicide. I also believed that her cancer was treatable and that her prospects were good. She was not, however, interested in treatment. She had made up her mind, but she continued to see me.

6. On the third or fourth visit, I asked her about her family and learned that she had a son. I asked her how he would feel if she went through with her plan. Shortly after that, she agreed to be treated and she is still alive today. Indeed, she is thrilled to be alive. It's been twelve years.

7. For Jeanette, the mere presence of legal assisted suicide had steered her to suicide.

8. Today, for patients under the Oregon Health Plan (Medicaid), there is also a financial incentive to commit suicide: The Plan covers the cost. The Plan's "Statements of Intent for the April 1, 2012 Prioritized List of Health Services," states:

It is the intent of the [Oregon Health Services] Commission that services under ORS 127.800-127.897 (Oregon Death with Dignity Act) be covered for those that wish to avail themselves to those services.

Attached hereto at page SI-1.

9. Under the Oregon Health Plan, there is also a financial incentive towards suicide because the Plan will not necessarily pay for a patient's treatment. For example, patients with cancer are denied treatment if they have a "less than 24 months median survival with treatment" and fit other criteria. This is the Plan's "Guideline Note 12." (Attached hereto at page GN-4).

10. The term, "less than 24 months median survival with treatment," means that statistically half the patients receiving treatment will live less than 24 months (two years) and the other half will live longer than two years.

11. Some of the patients living longer than two years will likely live far longer than two years, as much as five, ten or twenty years depending on the type of cancer. This is because there are always some people who beat the odds.

12. All such persons who fit within "Guideline Note 12" will nonetheless be denied treatment. Their suicides under Oregon's assisted suicide act will be covered.

13. I also write to clarify a difference between physician-assisted suicide and end-of-life palliative care in which dying patients receive medication for the intended purpose of relieving pain, which may incidentally hasten death. This is the principle of double effect. This is not physician-assisted suicide in which death is intended for patients who may or may not be dying anytime soon.

14. The Oregon Health Plan is a government health plan administered by the State of Oregon. If assisted suicide is legalized in Canada, your government health plan could follow a similar pattern. If so, the plan will pay for a patient to die, but not to live.

SWORN BEFORE ME at *Sherwood*
Oregon, USA
on *September 18,* 2012

NAME: *Jessica Borgo*

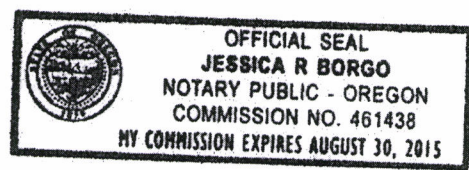
A notary in and for the
State of Oregon

ADDRESS: *16100 SW Tualatin - Sherwood Rd*

EXPIRY OF COMMISSION: *Aug, 30, 2015*

PLACE SEAL HERE: *Jessica Borgo*

Ken Stevens MD
Ken Stevens, MD



STATEMENT OF INTENT 1: PALLIATIVE CARE

It is the intent of the Commission that palliative care services be covered for patients with a life-threatening illness or severe advanced illness expected to progress toward dying, regardless of the goals for medical treatment and with services available according to the patient's expected length of life (see examples below).

Palliative care is comprehensive, specialized care ideally provided by an interdisciplinary team (which may include but is not limited to physicians, nurses, social workers, etc.) where care is particularly focused on alleviating suffering and promoting quality of life. Such interdisciplinary care should include assessment, care planning, and care coordination, emotional and psychosocial counseling for patients and families, assistance accessing services from other needed community resources, and should reflect the patient and family's values and goals.

Some examples of palliative care services that should be available to patients with a life-threatening/limiting illness,

- A) without regard to a patient's expected length of life:
 - Inpatient palliative care consultation; and,
 - Outpatient palliative care consultation, office visits.
- B) with an expected median survival of less than one year, as supported by the best available published evidence:
 - Home-based palliative care services (to be defined by DMAP), with the expectation that the patient will move to home hospice care.
- C) with an expected median survival of six months or less, as supported by peer-reviewed literature:
 - Home hospice care, where the primary goal of care is quality of life (hospice services to be defined by DMAP).

It is the intent of the Commission that certain palliative care treatments be covered when these treatments carry the primary goal to alleviate symptoms and improve quality of life, without intending to alter the trajectory of the underlying disease.

Some examples of covered palliative care treatments include:

- A) Radiation therapy for painful bone metastases with the intent to relieve pain and improve quality of life.
- B) Surgical decompression for malignant bowel obstruction.
- C) Medication therapy such as chemotherapy with low toxicity/low side effect agents with the goal to decrease pain from bulky disease or other identified complications. Cost of chemotherapy and alternative medication(s) should also be considered.
- D) Medical equipment and supplies (such as non-motorized wheelchairs, walkers, bandages, and catheters) determined to be medically appropriate for completion of basic activities of daily living, for management of symptomatic complications or as required for symptom control.
- E) Acupuncture with intent to relieve nausea.

Cancer treatment with intent to palliate is not a covered service when the same palliation can be achieved with pain medications or other non-chemotherapy agents.

It is NOT the intent of the Commission that coverage for palliative care encompasses those treatments that seek to prolong life despite substantial burdens of treatment and limited chance of benefit. See Guideline Note 12: TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE.

STATEMENT OF INTENT 2: DEATH WITH DIGNITY ACT

It is the intent of the Commission that services under ORS 127.800-127.897 (Oregon Death with Dignity Act) be covered for those that wish to avail themselves to those services. Such services include but are not limited to attending physician visits, consulting physician confirmation, mental health evaluation and counseling, and prescription medications.

STATEMENT OF INTENT 3: INTEGRATED CARE

Recognizing that many individuals with mental health disorders receive care predominantly from mental health care providers, and recognizing that integrating mental and physical health services for such individuals promotes patient-centered care, the Health Evidence Review Commission endorses the incorporation of chronic disease health management support within mental health service systems. Although such supports are not part of the mental health benefit package, mental health organizations (MHOs) that elect to provide these services may report them using psychiatric rehabilitation codes which pair with mental health diagnoses. If MHOs choose to provide tobacco cessation supports, they should report these services using 99407 for individual counseling and S9453 for classes.

GUIDELINE NOTE 9, WIRELESS CAPSULE ENDOSCOPY (CONT'D)

- b) Suspected Crohn's disease: upper and lower endoscopy, small bowel follow through
- 2) Radiological evidence of lack of stricture
- 3) Only covered once during any episode of illness
- 4) FDA approved devices must be used
- 5) Patency capsule should not be used prior to procedure

GUIDELINE NOTE 10, CENTRAL SEROUS RETINOPATHY AND PARS PLANITIS

Line 413

Central serous retinopathy (362.41) is included on this line only for treatment when the condition has been present for 3 months or longer. Pars planitis (363.21) should only be treated in patients with 20/40 or worse vision..

GUIDELINE NOTE 11, COLONY STIMULATING FACTOR (CSF) GUIDELINES

Lines 79,102,103,105,123-125,131,144,159,165,166,168,170,181,197,198,206-208,218,220,221,228,229,231,243,249,252,275-278,280,287,292,310-312,314,320,339-341,356,459,622

- A) CSF are not indicated for primary prophylaxis of febrile neutropenia unless the primary chemotherapeutic regimen is known to produce febrile neutropenia at least 20% of the time. CSF should be considered when the primary chemotherapeutic regimen is known to produce febrile neutropenia 10-20% of the time; however, if the risk is due to the chemotherapy regimen, other alternatives such as the use of less myelosuppressive chemotherapy or dose reduction should be explored in this situation.
- B) For secondary prophylaxis, dose reduction should be considered the primary therapeutic option after an episode of severe or febrile neutropenia except in the setting of curable tumors (e.g., germ cell), as no disease free or overall survival benefits have been documented using dose maintenance and CSF.
- C) CSF are not indicated in patients who are acutely neutropenic but afebrile.
- D) CSF are not indicated in the treatment of febrile neutropenia except in patients who received prophylactic filgrastim or sargramostim or in high risk patients who did not receive prophylactic CSF. High risk patients include those age >65 years or with sepsis, severe neutropenia with absolute neutrophil count <100/mcl, neutropenia expected to be more than 10 days in duration, pneumonia, invasive fungal infection, other clinically documented infections, hospitalization at time of fever, or prior episode of febrile neutropenia.
- E) CSF are not indicated to increase chemotherapy dose-intensity or schedule, except in cases where improved outcome from such increased intensity has been documented in a clinical trial.
- F) CSF (other than pegfilgrastim) are indicated in the setting of autologous progenitor cell transplantation, to mobilize peripheral blood progenitor cells, and after their infusion.
- G) CSF are NOT indicated in patients receiving concomitant chemotherapy and radiation therapy.
- H) There is no evidence of clinical benefit in the routine, continuous use of CSF in myelodysplastic syndromes. CSF may be indicated for some patients with severe neutropenia and recurrent infections, but should be used only if significant response is documented.
- I) CSF is indicated for treatment of cyclic, congenital and idiopathic neutropenia.

GUIDELINE NOTE 12, TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE

Lines 102,103,123-125,144,159,165,166,170,181,197,198,207,208,218,220,221,228,229,231,243,249,252,275-278,280,287,292,310-312,320,339-341,356,459,586,622

This guideline only applies to patients with advanced cancer who have less than 24 months median survival with treatment.

All patients receiving end of life care, either with the intent to prolong survival or with the intent to palliate symptoms, should have/be engaged with palliative care providers (for example, have a palliative care consult or be enrolled in a palliative care program).

Treatment with intent to prolong survival is not a covered service for patients with any of the following:

- Median survival of less than 6 months with or without treatment, as supported by the best available published evidence
- Median survival with treatment of 6-12 months when the treatment is expected to improve median survival by less than 50%, as supported by the best available published evidence
- Median survival with treatment of more than 12 months when the treatment is expected to improve median survival by less than 30%, as supported by the best available published evidence
- Poor prognosis with treatment, due to limited physical reserve or the ability to withstand treatment regimen, as indicated by low performance status.

Unpublished evidence may be taken into consideration in the case of rare cancers which are universally fatal within six months without treatment.

The Health Evidence Review Commission is reluctant to place a strict \$/QALY (quality adjusted life-year) or \$/LYS (life-year saved) requirement on end-of-life treatments, as such measurements are only approximations and cannot take into account all of the merits of an individual case. However, cost must be taken into consideration when considering treatment options near the end of life. For example, in no instance can it be justified to spend \$100,000 in public resources to increase an individual's expected survival by three months when hundreds of thousands of Oregonians are without any form of health insurance.

GUIDELINE NOTE 12, TREATMENT OF CANCER WITH LITTLE OR NO BENEFIT PROVIDED NEAR THE END OF LIFE (CONT'D)

Treatment with the goal to palliate is addressed in Statement of Intent 1, Palliative Care.

GUIDELINE NOTE 13, MINIMALLY INVASIVE CORONARY ARTERY BYPASS SURGERY

Lines 76,195

Minimally invasive coronary artery bypass surgery indicated only for single vessel disease.

GUIDELINE NOTE 14, SECOND BONE MARROW TRANSPLANTS

Lines 79,103,105,125,131,166,170,198,206,231,280,314

Second bone marrow transplants are not covered except for tandem autologous transplants for multiple myeloma.

GUIDELINE NOTE 15, HETEROTOPIC BONE FORMATION

Lines 89,384

Radiation treatment is indicated only in those at high risk of heterotopic bone formation: those with a history of prior heterotopic bone formation, ankylosing spondylitis or hypertrophic osteoarthritis.

GUIDELINE NOTE 16, CYSTIC FIBROSIS CARRIER SCREENING

Lines 1,3,4

Cystic fibrosis carrier testing is covered for 1) non-pregnant adults if indicated in the genetic testing algorithm or 2) pregnant women.

GUIDELINE NOTE 17, PREVENTIVE DENTAL CARE

Line 58

Dental cleaning and fluoride treatments are limited to once per 12 months for adults and twice per 12 months for children up to age 19 (D1110, D1120, D1203, D1204, D1206). More frequent dental cleanings and/or fluoride treatments may be required for certain higher risk populations.

GUIDELINE NOTE 18, VENTRICULAR ASSIST DEVICES

Lines 108,279

Ventricular assist devices are covered only in the following circumstances:

- A) as a bridge to cardiac transplant;
- B) as treatment for pulmonary hypertension when pulmonary hypertension is the only contraindication to cardiac transplant and the anticipated outcome is cardiac transplant; or,
- C) as a bridge to recovery.

Ventricular assist devices are not covered for destination therapy.

Ventricular assist devices are covered for cardiomyopathy only when the intention is bridge to cardiac transplant.

GUIDELINE NOTE 19, PET SCAN GUIDELINES

Lines 125,144,165,166,170,182,207,208,220,221,243,276,278,292,312,339

PET Scans are covered for diagnosis of the following cancers only:

- Solitary pulmonary nodules and non-small cell lung cancer
- Evaluation of cervical lymph node metastases when CT or MRI do not demonstrate an obvious primary tumor.

For diagnosis, PET is covered only when it will avoid an invasive diagnostic procedure, or will assist in determining the optimal anatomic location to perform an invasive diagnostic procedure.

PET scans are covered for the initial staging of the following cancers:

- Cervical cancer only when initial MRI or CT is negative for extra-pelvic metastasis
- Head and neck cancer when initial MRI or CT is equivocal

CANADA

C O U R S U P É R I E U R E

PROVINCE DE QUÉBEC

DISTRICT DE TROIS-RIVIÈRES

No. : 400-17-002642-110

GINETTE LEBLANC,
demanderesse

c.

PROCUREUR GÉNÉRAL DU CANADA,
défendeur

et

PROCUREUR GÉNÉRAL DU QUÉBEC,
mis-en-cause

**AFFIDAVIT OF JOHN NORTON IN OPPOSITION TO
ASSISTED SUICIDE AND EUTHANASIA**

THE UNDERSIGNED, being first duly sworn on oath, STATES:

1. I live in Florence Massachusetts USA. When I was eighteen years old and in my first year of college, I was diagnosed with Amyotrophic Lateral Sclerosis (ALS) by the University of Iowa Medical School. ALS is commonly referred to as Lou Gehrig's disease. I was told that I would get progressively worse (be paralyzed) and die in three to five years.
2. I was a very physical person. The diagnosis was devastating to me. I had played football in high school and was extremely active riding bicycles. I also performed heavy labor including road construction and farm work. I prided myself for my physical strength, especially in my hands.
3. The ALS diagnosis was confirmed by the Mayo Clinic in Rochester Minnesota. I was eighteen or nineteen years old at the

AFFIDAVIT OF JOHN NORTON- Page 1

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time. By then, I had twitching in both hands, which were also getting weaker. At some point, I lost the ability to grip in my hands. I became depressed and was treated for my depression. If instead, I had been told that my depression was rational and that I should take an easy way out with a doctor's prescription and support, I would have taken that opportunity.

4. Six years after my initial diagnosis, the disease progression stopped. Today, my condition is about the same. I still can't grip with my hands. Sometimes I need special help. But, I have a wonderful life. I am married to Susan. We have three children and one grandchild. I have a degree in Psychology and one year of graduate school. I am a retired bus driver (no gripping required). Prior to driving bus, I worked as a parole and probation officer. When I was much younger, I drove a school bus. We have wonderful friends. I enjoy singing tenor in amateur choruses. I help other people by working as a volunteer driver.

5. I will be 75 years old this coming September. If assisted suicide or euthanasia had been available to me in the 1950's, I would have missed the bulk of my life and my life yet to come. I hope that Canada does not legalize these practices.

SWORN BEFORE ME at
MASSACHUSETTS, USA
on, August 18th, 2012

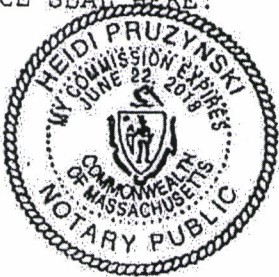
NAME: Heidi Pruzynski
Heidi

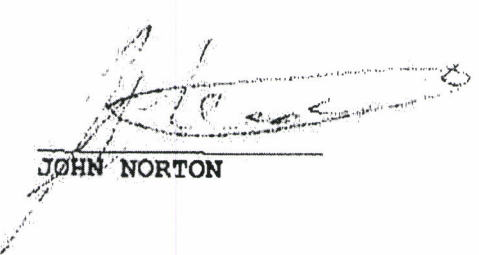
A notary in and for the
State of Washington MASSACHUSETTS

ADDRESS: 85 Main St
Florence MA 01062

EXPIRY OF COMMISSION: June 22, 2018

PLACE SEAL HERE:




JOHN NORTON

AFFIDAVIT OF JOHN NORTON- Page 3

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CANADA

C O U R S U P É R I E U R E

PROVINCE DE QUÉBEC

DISTRICT DE TROIS-RIVIÈRES

No. : 400-17-002642-110

GINETTE LEBLANC,
demanderesse

c.

PROCUREUR GÉNÉRAL DU CANADA,
défendeur

et

PROCUREUR GÉNÉRAL DU QUÉBEC,
mis-en-cause

**AFFIDAVIT OF JEANETTE HALL
OPPOSING ASSISTED SUICIDE**

THE UNDERSIGNED, being first duly sworn under oath, states:

1. I live in Oregon where physician-assisted suicide is legal. Our law was enacted in 1997 via a ballot initiative that I voted for.

2. In 2000, I was diagnosed with cancer and told that I had 6 months to a year to live. I knew that our law had passed, but I didn't know exactly how to go about doing it. I tried to ask my doctor, Ken Stevens MD, but he didn't really answer me. In hindsight, he was stalling me.

3. I did not want to suffer. I wanted to do our law and I wanted Dr. Stevens to help me. Instead, he encouraged me to not give up and ultimately I decided to fight the cancer. I had both chemotherapy and radiation. I am so happy to be alive!

Affidavit of Jeanette Hall - Page 1

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4. This July, it was 12 years since my diagnosis. If Dr. Stevens had believed in assisted suicide, I would be dead. Assisted suicide should not be legal.

Dated this 17th day of August 2012

Jeanette Hall
Jeanette Hall

SWORN BEFORE ME at
OREGON, USA
on, August 17, 2012

NAME: Sheena Leslie

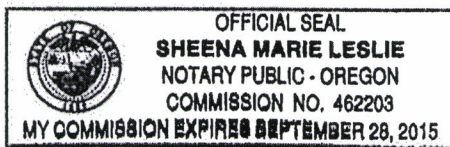
JEANETTE HALL

A notary in and for the
State of Oregon

ADDRESS: 15105 SW 116th Ave
Tigard, OR 97224

EXPIRY OF COMMISSION:
September 28, 2012

PLACE SEAL HERE:



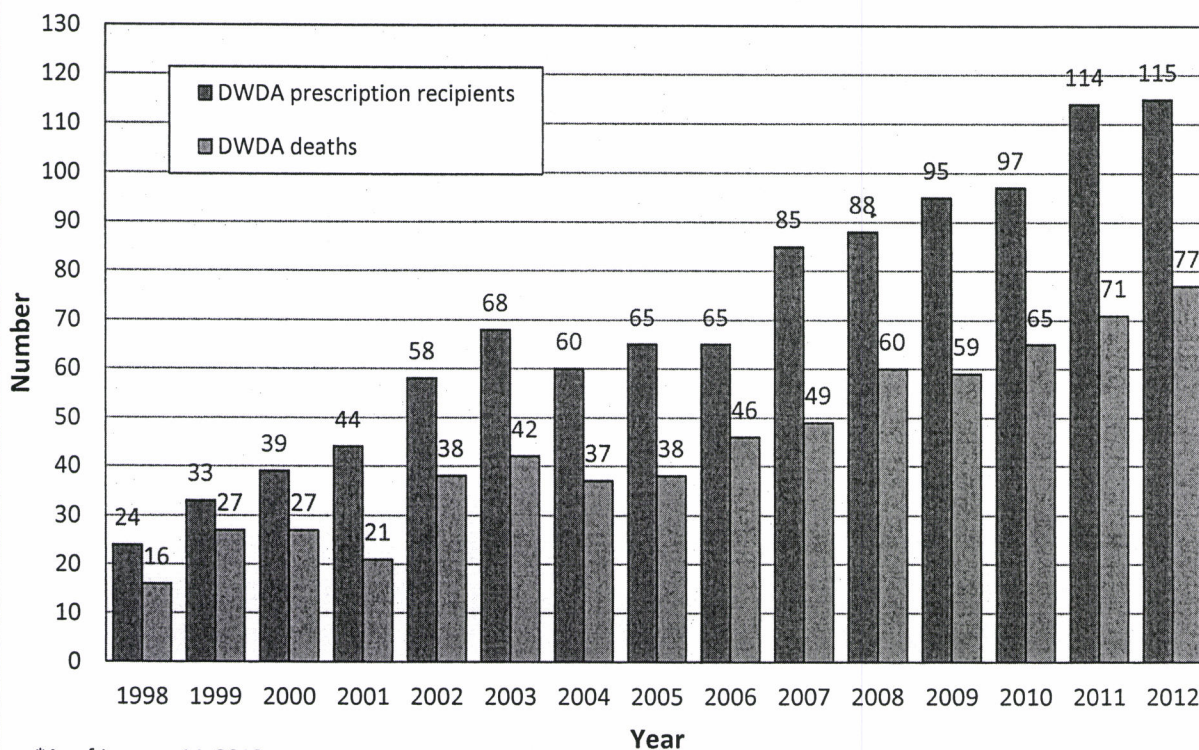
Affidavit of Jeanette Hall - Page 2

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Oregon's Death with Dignity Act--2012

Oregon's Death with Dignity Act (DWDA), enacted in late 1997, allows terminally-ill adult Oregonians to obtain and use prescriptions from their physicians for self-administered, lethal doses of medications. The Oregon Public Health Division is required by the Act to collect information on compliance and to issue an annual report. The key findings from 2012 are listed below. The number of people for whom DWDA prescriptions were written (DWDA prescription recipients) and deaths that occurred as a result of ingesting prescribed DWDA medications (DWDA deaths) reported in this summary are based on paperwork and death certificates received by the Oregon Public Health Division as of January 14, 2013. For more detail, please view the figures and tables on our web site: <http://www.healthoregon.org/dwd>.

**Figure 1: DWDA prescription recipients and deaths*,
by year, Oregon, 1998-2012**



*As of January 14, 2013

- As of January 14, 2013, prescriptions for lethal medications were written for 115 people during 2012 under the provisions of the DWDA, compared to 114 during 2011 (Figure 1). At the time of this report, there were 77 known DWDA deaths during 2012. This corresponds to 23.5 DWDA deaths per 10,000 total deaths.¹

¹ Rate per 10,000 deaths calculated using the total number of Oregon resident deaths in 2011 (32,731), the most recent year for which final death data is available.

- Since the law was passed in 1997, a total of 1,050 people have had DWDA prescriptions written and 673 patients have died from ingesting medications prescribed under the DWDA.
- Of the 115 patients for whom DWDA prescriptions were written during 2012, 67 (58.3%) ingested the medication; 66 died from ingesting the medication, and one patient ingested the medication but regained consciousness before dying of underlying illness and is therefore not counted as a DWDA death. The patient regained consciousness two days following ingestion, but remained minimally responsive and died six days following ingestion.
- Eleven (11) patients with prescriptions written during the previous year (2011) died after ingesting the medication during 2012.
- Twenty-three (23) of the 115 patients who received DWDA prescriptions during 2012 did not take the medications and subsequently died of other causes.
- Ingestion status is unknown for 25 patients who were prescribed DWDA medications in 2012. Fourteen (14) of these patients died, but follow-up questionnaires indicating ingestion status have not yet been received. For the remaining 11 patients, both death and ingestion status are pending (Figure 2).
- Of the 77 DWDA deaths during 2012, most (67.5%) were aged 65 years or older; the median age was 69 years. As in previous years, most were white (97.4%), well-educated (42.9% had a least a baccalaureate degree), and had cancer (75.3%).
- Most (97.4%) patients died at home; and most (97.0%) were enrolled in hospice care either at the time the DWDA prescription was written or at the time of death. Excluding unknown cases, all (100.0%) had some form of health care insurance, although the number of patients who had private insurance (51.4%) was lower in 2012 than in previous years (66.2%), and the number of patients who had only Medicare or Medicaid insurance was higher than in previous years (48.6% compared to 32.1%).
- As in previous years, the three most frequently mentioned end-of-life concerns were: loss of autonomy (93.5%), decreasing ability to participate in activities that made life enjoyable (92.2%), and loss of dignity (77.9%).
- Two of the 77 DWDA patients who died during 2012 were referred for formal psychiatric or psychological evaluation. Prescribing physicians were present at the time of death for seven patients (9.1%) during 2012 compared to 17.3% in previous years.
- A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about the time of death and circumstances surrounding death only when the physician or another health care provider was present at the time of death. Due to this change, data on time from ingestion to death is available for 11 of the 77 DWDA deaths during 2012. Among those 11 patients, time from ingestion until death ranged from 10 minutes to 3.5 hours.

- Sixty-one (61) physicians wrote the 115 prescriptions provided during 2012 (range 1-10 prescriptions per physician).
- During 2012, no referrals were made to the Oregon Medical Board for failure to comply with DWDA requirements.

Figure 2: Summary of DWDA prescriptions written and medications ingested in 2012, as of January 14, 2013

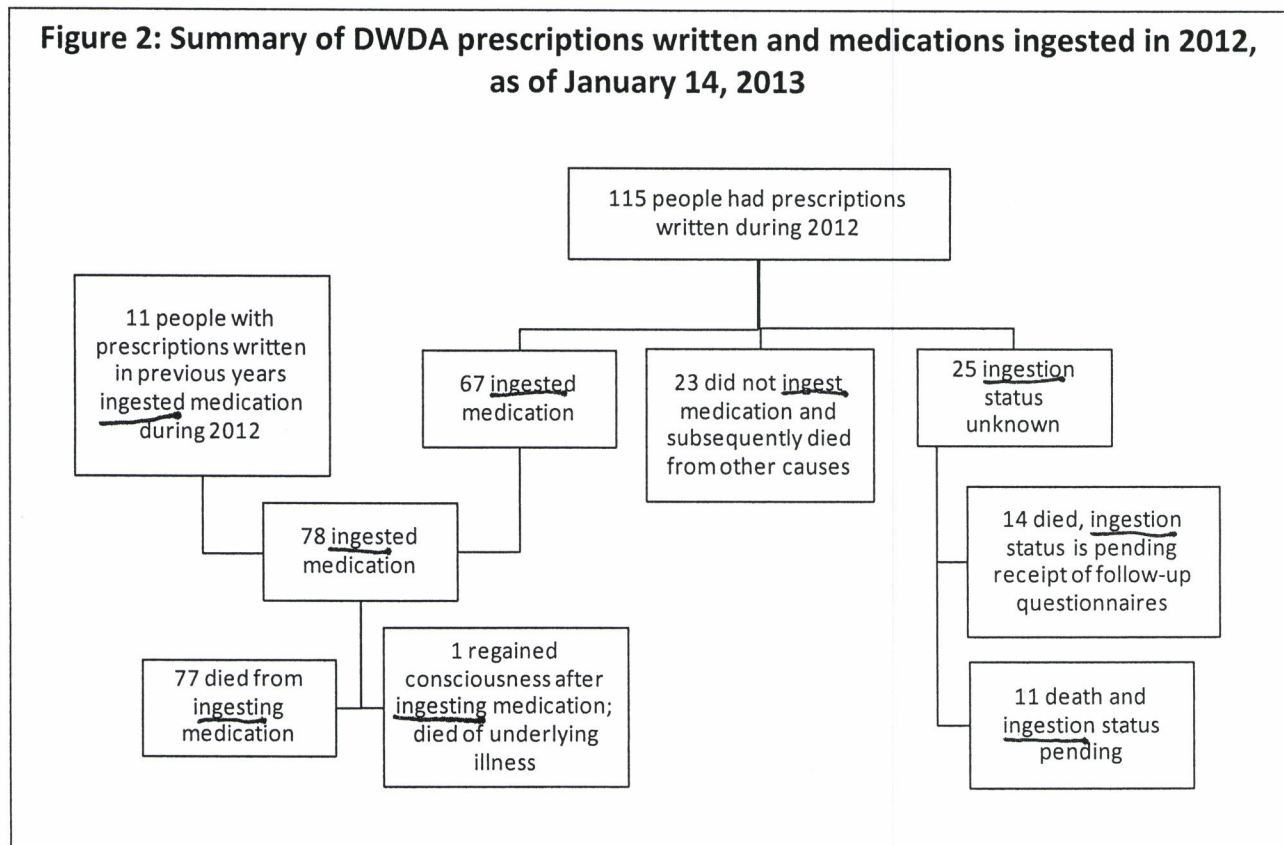


Table 1. Characteristics and end-of-life care of 673 DWDA patients who have died from ingesting a lethal dose of medication as of January 14, 2013, by year, Oregon, 1998-2012

Characteristics	2012 (N=77)	1998-2011 (N=596)	Total (N=673)
Sex	N (%) ¹	N (%) ¹	N (%) ¹
Male (%)	39 (50.6)	308 (51.7)	347 (51.6)
Female (%)	38 (49.4)	288 (48.3)	326 (48.4)
Age			
18-34 (%)	0 (0.0)	6 (1.0)	6 (0.9)
35-44 (%)	1 (1.3)	14 (2.3)	15 (2.2)
45-54 (%)	8 (10.4)	44 (7.4)	52 (7.7)
55-64 (%)	16 (20.8)	123 (20.6)	139 (20.7)
65-74 (%)	23 (29.9)	170 (28.5)	193 (28.7)
75-84 (%)	18 (23.4)	168 (28.2)	186 (27.6)
85+ (%)	11 (14.3)	71 (11.9)	82 (12.2)
Median years (range)	69 (42-96)	71 (25-96)	71 (25-96)
Race			
White (%)	75 (97.4)	579 (97.6)	654 (97.6)
African American (%)	0 (0.0)	1 (0.2)	1 (0.1)
American Indian (%)	0 (0.0)	1 (0.2)	1 (0.1)
Asian (%)	1 (1.3)	7 (1.2)	8 (1.2)
Pacific Islander (%)	0 (0.0)	1 (0.2)	1 (0.1)
Other (%)	0 (0.0)	0 (0.0)	0 (0.0)
Two or more races (%)	0 (0.0)	0 (0.0)	0 (0.0)
Hispanic (%)	1 (1.3)	4 (0.7)	5 (0.7)
Unknown	0	3	3
Marital Status			
Married (%) ²	33 (42.9)	271 (45.7)	304 (45.4)
Widowed (%)	23 (29.9)	134 (22.6)	157 (23.4)
Never married (%)	6 (7.8)	49 (8.3)	55 (8.2)
Divorced (%)	15 (19.5)	139 (23.4)	154 (23.0)
Unknown	0	3	3
Education			
Less than high school (%)	2 (2.6)	40 (6.8)	42 (6.3)
High school graduate (%)	13 (16.9)	139 (23.5)	152 (22.8)
Some college (%)	29 (37.7)	148 (25.0)	177 (26.5)
Baccalaureate or higher (%)	33 (42.9)	264 (44.7)	297 (44.5)
Unknown	0	5	5
Residence			
Metro counties (%) ³	34 (44.2)	253 (42.7)	287 (42.8)
Coastal counties (%)	4 (5.2)	47 (7.9)	51 (7.6)
Other western counties (%)	37 (48.1)	250 (42.2)	287 (42.8)
East of the Cascades (%)	2 (2.6)	43 (7.3)	45 (6.7)
Unknown	0	3	3
End of life care			
Hospice			
Enrolled (%) ⁴	64 (97.0)	522 (89.7)	586 (90.4)
Not enrolled (%)	2 (3.0)	60 (10.3)	62 (9.6)
Unknown	11	14	25
Insurance			
Private (%) ⁵	36 (51.4)	382 (66.2)	418 (64.6)
Medicare, Medicaid or Other Governmental (%)	34 (48.6)	185 (32.1)	219 (33.8)
None (%)	0 (0.0)	10 (1.7)	10 (1.5)
Unknown	7	19	26

Characteristics	2012 (N=77)	1998-2011 (N=596)	Total (N=673)
Underlying illness			
Malignant neoplasms (%)	58 (75.3)	480 (80.9)	538 (80.3)
Lung and bronchus (%)	14 (18.2)	112 (18.9)	126 (18.8)
Breast (%)	4 (5.2)	52 (8.8)	56 (8.4)
Colon (%)	7 (9.1)	36 (6.1)	43 (6.4)
Pancreas (%)	2 (2.6)	42 (7.1)	44 (6.6)
Prostate (%)	5 (6.5)	26 (4.4)	31 (4.6)
Ovary (%)	2 (2.6)	25 (4.2)	27 (4.0)
Other (%)	24 (31.2)	187 (31.5)	211 (31.5)
Amyotrophic lateral sclerosis (%)	5 (6.5)	44 (7.4)	49 (7.3)
Chronic lower respiratory disease (%)	2 (2.6)	25 (4.2)	27 (4.0)
Heart Disease (%)	2 (2.6)	10 (1.7)	12 (1.8)
HIV/AIDS (%)	1 (1.3)	8 (1.3)	9 (1.3)
Other illnesses (%) ⁶	9 (11.7)	26 (4.4)	35 (5.2)
Unknown	0	3	3
DWDA process			
Referred for psychiatric evaluation (%)	2 (2.6)	40 (6.7)	42 (6.2)
Patient informed family of decision (%) ⁷	71 (92.2)	493 (94.4)	564 (94.2)
Patient died at			
Home (patient, family or friend) (%)	75 (97.4)	562 (94.8)	637 (95.1)
Long term care, assisted living or foster care facility (%)	2 (2.6)	25 (4.2)	27 (4.0)
Hospital (%)	0 (0.0)	1 (0.2)	1 (0.1)
Other (%)	0 (0.0)	5 (0.8)	5 (0.7)
Unknown	0	3	3
Lethal medication			
Secobarbital (%)	20 (26.0)	374 (62.8)	394 (58.5)
Pentobarbital (%)	57 (74.0)	215 (36.1)	272 (40.4)
Other (%) ⁸	0 (0.0)	7 (1.2)	7 (1.0)
End of life concerns⁹			
	(N=77)	(N=592)	(N=669)
Losing autonomy (%)	72 (93.5)	538 (90.9)	610 (91.2)
Less able to engage in activities making life enjoyable (%)	71 (92.2)	523 (88.3)	594 (88.8)
Loss of dignity (%) ¹⁰	60 (77.9)	386 (82.7)	446 (82.0)
Losing control of bodily functions (%)	27 (35.1)	318 (53.7)	345 (51.6)
Burden on family, friends/caregivers (%)	44 (57.1)	214 (36.1)	258 (38.6)
Inadequate pain control or concern about it (%)	23 (29.9)	134 (22.6)	157 (23.5)
Financial implications of treatment (%)	3 (3.9)	15 (2.5)	18 (2.7)
Health-care provider present¹¹			
	(N=77)	(N=526)	(N=603)
When medication was ingested ¹²			
Prescribing physician	8	100	108
Other provider, prescribing physician not present	4	231	235
No provider	1	72	73
Unknown	64	123	187
At time of death			
Prescribing physician (%)	7 (9.1)	89 (17.3)	96 (16.2)
Other provider, prescribing physician not present (%)	4 (5.2)	254 (49.4)	258 (43.7)
No provider (%)	66 (85.7)	171 (33.3)	237 (40.1)
Unknown	0	12	12
Complications¹²			
	(N=77)	(N=596)	(N=673)
Regurgitated	0	22	22
Seizures	0	0	0
None	11	463	474
Unknown	66	111	177
Other outcomes			
Regained consciousness after ingesting DWDA medications ¹³	1	5	6

Characteristics	2012 (N=77)	1998-2011 (N=596)	Total (N=673)
Timing of DWDA event			
Duration (weeks) of patient-physician relationship ¹⁴			
Median	19	12	12
Range	0-1640	0-1905	0-1905
Number of patients with information available	77	594	671
Number of patients with information unknown	0	2	2
Duration (days) between 1st request and death			
Median	47	46	46
Range	16-388	15-1009	15-1009
Number of patients with information available	77	596	673
Number of patients with information unknown	0	0	0
Minutes between ingestion and unconsciousness ¹¹			
Median	5	5	5
Range	3-15	1-38	1-38
Number of patients with information available	11	462	473
Number of patients with information unknown	66	134	200
Minutes between ingestion and death ¹¹			
Median	20	25	25
Range (minutes - hours)	10min-3.5hrs	1min-104hrs	1min-104hrs
Number of patients with information available	11	467	478
Number of patients with information unknown	66	129	195

¹ Unknowns are excluded when calculating percentages.

² Includes Oregon Registered Domestic Partnerships.

³ Clackamas, Multnomah, and Washington counties.

⁴ Includes patients that were enrolled in hospice at the time the prescription was written or at time of death.

⁵ Private insurance category includes those with private insurance alone or in combination with other insurance.

⁶ Includes deaths due to benign and uncertain neoplasms, other respiratory diseases, diseases of the nervous system (including multiple sclerosis, Parkinson's disease and Huntington's disease), musculoskeletal and connective tissue diseases, viral hepatitis, diabetes mellitus, cerebrovascular disease, and alcoholic liver disease.

⁷ First recorded beginning in 2001. Since then, 24 patients (4.0%) have chosen not to inform their families, and 11 patients (1.8%) have had no family to inform. There was one unknown case in 2002, two in 2005, and one in 2009.

⁸ Other includes combinations of secobarbital, pentobarbital, and/or morphine.

⁹ Affirmative answers only ("Don't know" included in negative answers). Categories are not mutually exclusive. Data unavailable for four patients in 2001.

¹⁰ First asked in 2003. Data available for all 77 patients in 2012, 467 patients between 1998-2011, and 544 patients for all years.

¹¹ The data shown are for 2001-2012 since information about the presence of a health care provider/volunteer, in the absence of the prescribing physician, was first collected in 2001.

¹² A procedure revision was made mid-year in 2010 to standardize reporting on the follow-up questionnaire. The new procedure accepts information about time of death and circumstances surrounding death only when the physician or another health care provider is present at the time of death. This resulted in a larger number of unknowns beginning in 2010.

¹³ There have been a total of six patients who regained consciousness after ingesting prescribed lethal medications. These patients are not included in the total number of DWDA deaths. These deaths occurred in 2005 (1 death), 2010 (2 deaths), 2011 (2 deaths) and 2012 (1 death). Please refer to the appropriate years' annual reports on our website (<http://www.healthoregon.org/dwd>) for more detail on these deaths.

¹⁴ Previous reports listed 20 records missing the date care began with the attending physician. Further research with these cases has reduced the number of unknowns.

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ingest definition

in·gest (in jest')

transitive verb

to take (food, drugs, etc.) into the body, as by swallowing, inhaling, or absorbing

Origin: < L *ingestus*, pp. of *ingerere*, to carry, put into < *in-*, into + *gerere*, to carry

Related Forms:

- **ingestion** in-ges'-tion *noun*
- **ingestive** in-ges'-tive *adjective*

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in·gest (in-jest')

transitive verb in-gest-ed, in-gest-ing, in-gests

1. To take into the body by the mouth for digestion or absorption. See Synonyms at eat.
2. To take in and absorb as food: "*Marine ciliates ... can be observed ... ingesting other single-celled creatures and harvesting their chloroplasts*" (Carol Kaesuk Yoon).





Origin: Latin *ingerere*, ingest- : *in-*, in; see in-² + *gerere*, to carry.

Related Forms:

- **in·gest'i·ble** *adjective*
- **ingestion** in-ges'tion *noun*
- **ingestive** in-ges'tive *adjective*

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Opinion 2.21 - Euthanasia

X Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient's intolerable and incurable suffering.

It is understandable, though tragic, that some patients in extreme duress--such as those suffering from a terminal, painful, debilitating illness--may come to decide that death is preferable to life. However, permitting physicians to engage in euthanasia would ultimately cause more harm than good. Euthanasia is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient's life. Euthanasia could also readily be extended to incompetent patients and other vulnerable populations.

Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication. (I, IV)

Issued June 1994 based on the report "[Decisions Near the End of Life](#)," adopted June 1991 (JAMA. 1992; 267: 2229-2233); Updated June 1996

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n.

Euthanasia.

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mercy killing.See euthanasia, def 1.

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mercy killing

the euthanasia of animals for humane reasons is regarded by the veterinary profession as one of its responsibilities to the animal population. When the animal is in a great deal of pain and there is no chance of a favorable outcome, it is thought that the veterinarian is required to carry out euthanasia. In most Western countries this is enshrined in legislation relating to the protection of animals against cruelty. In awkward situations, e.g. when the owner resists or is not available to give consent to euthanasia, it is prudent to get another veterinary opinion if that is possible.

Saunders Comprehensive Veterinary Dictionary, 3 ed. © 2007 Elsevier, Inc. All rights reserved

mercy killingMedical ethics The termination of a person's life as a humane act. See Euthanasia.

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June 10, 2009

Forum will focus on the rapid growth in abuse of elders

The statistics are frightening, and unless human nature takes a turn for the better, they're almost certain to get worse.

We're talking about the numbers of seniors who fall victim to abuse, exploitation or neglect — in Montana.

The graphic at right shows a substantial year-over-year increase in cases — 22 percent for abuse, for example — but the numbers over the past decade in our nine-county region are even more dramatic.

Abuse cases nearly doubled, and exploitation and neglect cases both tripled from 1998 to 2008.

The state division of Adult Protective Services expects the trend to worsen.

"I anticipate that the economic stresses ... the increase in gambling addiction, the increase in child support payment enforcement and the unrealistic lifestyle expectation of the younger generation will contribute to the increased referrals," said division Director Rick Bartos.

Sheer numbers of seniors will contribute further as baby boomers age — the so-called "golden years" also are the years of increased vulnerability.

To help area residents and officials prepare and cope with these seemingly inevitable trends, an organization called the Elder Abuse Prevention Forum will sponsor a public meeting at the Rainbow Assisted Living Community from 1-7 p.m. Friday, which happens to be National Elder Abuse Prevention Day.

The public is invited, and there's no charge.

Speakers will include Sgt. Jeff Newton, Great Falls Police Department; Jim Francetich, Adult Protective Services; Sheriff Dave Castle; County Attorney John Parker; and District Judge Dirk Sandefur.

There also will be 30 booths from vendors who serve seniors. The forum is a grass-roots coalition of groups and individuals.

KULR-8 News, Sports, Weather - Billings, Montana Local Coupons

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Elder Abuse Prevention

Originally printed at <http://www.kulr8.com/news/local/96428934.html>

By Nicole Grigg
June 15, 2010

BILLINGS - Elderly people across the country are victims of abuse on a daily basis. A Billings organization was one of the first in the nation to spread awareness of this often unseen abuse.

There are many warning signs to look for if your loved one is being victimized and different types of abuse. There's physical, emotional, psychological, and sexual.

Social worker Nikki Nielsen is talking about the different forms of elder abuse. She's handling 40 cases right now in Billings. Big Sky Senior Services works to prevent abuse, neglect and financial exploitation of seniors age 60 and older.

"Someone's relative coming and saying they are going to help out and in fact they end up getting hold of the person's bank account and unfortunately wiping out their savings they saved up all their lives," is the most common cases Nielsen said she sees.

Only one in ten cases of elder abuse is actually reported. More than 900 cases of abuse were reported in Montana last year. Director of Big Sky services Denise Armstrong said financial exploitation is the fastest growing form of abuse because elders are so trustworthy.

"I encourage all seniors to review their bank statements every single month. Protect your identification and if someone calls asking for your account number or social security number never give out your information over the phone. The other thing we always say if it sounds too good to be true, then it is too good to be true," said Armstrong.

Armstrong said one reason elder abuse is so underreported is that often time the victimizer is a family member and the elderly victim doesn't want to get them in trouble.



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What is Elder Abuse

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[Psychological/Emotional Abuse](#) • [Abandonment](#)
[Self-Neglect](#) • [Sexual Abuse](#) • [Financial Abuse](#)
 • [Signs of Distress](#) • [Two Case Studies](#)

Physical Abuse

Any physical pain or injury that is willfully inflicted upon an elder by a person who has care of or custody of, or who stands in a position of trust with that elder, constitutes physical abuse. This includes, but is not limited to, direct beatings, sexual assault, unreasonable physical restraint, and prolonged deprivation of food or water.



Possible Indicators of Physical Abuse

- Cuts, lacerations, puncture wounds
- Bruises, welts, discoloration
- Any injury incompatible with history
- Any injury which has not been properly addressed
- Poor skin condition or poor skin hygiene
- Absence of hair and/or hemorrhaging below the scalp
- Dehydration and/or malnourished without illness-related cause
- Weight loss
- Burns: may be caused by cigarettes, caustics, acids, friction from ropes or chains, or other objects
- Soiled clothing or bed

Neglect and Abuse by Caregiver

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The failure of any person having the care or custody of an elder to provide that degree of care which a reasonable person in a like position would provide constitutes neglect. This includes, but is not limited to:

1. Failure to assist in personal hygiene or the provision of clothing for an elder
2. Failure to provide medical care for the physical and mental health needs of an elder
3. Failure to protect an elder from health and safety standards

Possible Indicators of Neglect by Caregiver:

- Dirt, fecal/urine smell, or other health and safety hazards in elder's living environment
- Rashes, sores, lice on elder

- Inadequate clothing
- Elder is malnourished or dehydrated
- Elder has an untreated medical condition

Possible Indicators of Abuse by Caregiver:

- The elder may not have been given an opportunity to speak for him or herself, or see others without the presence of the caregiver.
- Attitude of indifference or anger toward the dependent person, or the obvious absence of assistance
- Family members or caregiver blames the elder
- Aggressive behavior by caregiver toward the elder (threats, insults, harassment)
- Previous history of abuse of others
- Problem with alcohol or drugs
- Inappropriate display of affection by the caregiver
- Flirtations, coyness, etc. as possible indicators of inappropriate sexual relationship
- Social isolation of family, or isolation or restriction of activity of the older adult within the family unit by the caregiver
- Conflicting accounts of incidents by family, supporters, or victim
- Unwillingness or reluctance by the caregiver to comply with service providers in planning and implementing care-plan
- Inappropriate or unwarranted defensiveness by caregiver

Psychological/Emotional Abuse[\[Back to Top\]](#)

The willful infliction of mental suffering, by a person in a position of trust with an elder, constitutes psychological/emotional abuses. Example of such abuse are: verbal assaults, threats, instilling fear, humiliation, intimidation, or isolation of an elder.

Abandonment[\[Back to Top\]](#)

Abandonment constitutes the desertion or willful forsaking of an elder by a person having the care and custody of that elder, under circumstances in which a reasonable person will continue to provide care or custody.

Self-Neglect[\[Back to Top\]](#)

Failure to provide for self through inattention or dissipation. The identification of this type of cause depends on assessing the elder's ability to choose a lifestyle versus a recent change in the elder's ability to manage.

Sexual Abuse[\[Back to Top\]](#)

The non-consensual sexual contact of any kind with an elderly person.

Financial Abuse[\[Back to Top\]](#)

Financial Exploitation means the initial depletion of bank account, credit accounts or other resources for the benefit or advantage of the offender.

Possible indicators of Financial Abuse:

- Unusual or inappropriate activity in bank accounts
- Signatures on checks, etc. that do not resemble the older person's signature, or signed when the elder person cannot write
- Power of attorney given, or recent changes or creation of will, when the person is incapable of making such decisions
- Unusual concern by caregiver that an excessive amount of money is being expended on the care of the person
- Numerous unpaid bills, overdue rent, when someone is supposed to be paying the bills for a dependent elder
- Placement in nursing home or residential care facility which is not commensurate with alleged size of estate

- Lack of amenities, such as TV, personal grooming items, appropriate clothing, that the estate can well afford

An elderly person may be at risk for abuse, neglect and/or exploitation if:

- The level of care they are receiving is inconsistent with their resources or needs
- They seem nervous or afraid of the person accompanying or 'helping' them
- Someone displays sudden attention or affection for the elder
- Someone promises life-long care in exchange for property
- They are unable to remember signing documents or making financial transactions
- Someone is attempting to isolate them from family or other support
- Property is transferred to someone else or is reported missing
- They seem confused about transactions or withdrawals from their account
- They seem coerced into making transactions
- The elder or the acquaintance gives implausible explanations of finances or expenses
- Sudden changes in the elder's appearance or self-care
- The elder becomes emotionally or physically withdrawn
- A professional 'assisting' them behaves or responds questionably

Financial exploitation of our elderly is a growing problem and is under reported by the victim's family or caregivers. Financial exploitation means the intentional depletion of bank account, credit accounts or other resources for the benefit or advantage of the offender. Victims of financial exploitation may live in the community or in a health care facility; may be in poor health or have a diminished mental capacity and can be easily swayed. The motivation of the offender to steal will probably fall into one of two categories; greed or desperation.

Financial abuse robs many elderly victims of their homes, life savings and possessions, as well as their dignity and independence. The damage is devastating because it comes at a time when the elderly victim is least likely to recover what they have lost.

To help prevent the depletion of an elder's financial assets, Big Sky Prevention of Elder Abuse Program formed a Task Force that developed an effective training model for reporting suspect situations. This Financial Exploitation Training Manual, Video and PowerPoint includes forms, procedures and remedies for reporting to the appropriate authorities when abuse is detected and is available to the public.

Signs of Distress

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- Unkempt lawns/walks
- Disheveled personal appearance
- Loss of hearing, vision, weight, difficulty moving about
- Increased withdrawal, isolation
- Disorientation, forgetfulness, confusion
- Any marked change in overall ability to function>

Two Case Studies

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Medical Neglect

A call was received concerning an elderly man residing in an unlicensed care home. Harold was placed in the home by a relative when his care needs became too great for her to manage. Harold exhibits dementia, hearing impairment, and incontinence of urine. He ambulates with a walker and is prone to falls.

After slipping in the bathroom one evening, Harold sustained a five-inch laceration to his right calf. The care provider transported Harold to the emergency room where the cut was sutured. Care instructions and recommendations for follow-up treatment were given. Several weeks passed and Harold was seen again in the emergency room. The

laceration was severely infected. A physician had not checked the injury since it was originally sutured. Harold was admitted to the hospital and the wound was derided. A skin graft was ultimately needed to adequately repair the wound. An extended hospital stay was required.

After reviewing the records, consulting a medical staff and interviewing the parties involved, it was determined that the provider failed to obtain appropriate medical care as recommended. Medical neglect was substantiated. It was further recommended that the provider's application for care license be denied.

Financial Exploitation

A call was received concerning Hank, an elderly man in his late 70's. An unusual amount of activity had occurred in Hank's banking account over the last several weeks. Large sums of money had been withdrawn.

The Social Worker visited him and determined that Hank is nearly blind and there is a question about his mental abilities. Hank became acquainted with a man named Richard about six months ago, after Richard answered a help wanted ad in the newspaper. Hank had been looking for someone to assist with grocery shopping, errands, and a few chores around the house.

Hank and Richard hit it off right away. Hank felt fortunate to find someone so responsible and helpful as it had been getting really hard to manage a home alone. Hank quickly became dependent on Richard for assistance in many activities. Before long, Richard was involved with bill paying. Hank came to trust Richard and, since he could not see, simply signed checks for whatever bill Richard presented to him.

The Social Worker was able to look at various bank statements and piece together checking and saving account withdrawals in excess of \$50,000.00. A determination of financial exploitation was substantiated. The case was referred to law enforcement and the County Attorney for prosecution. A retired bank officer was located who agreed to serve as guardian/conservator of Hank. Hank continued to live in his home with assistance until his death.

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Dutch law allows euthanasia

Dear Editor:

I am a physician who has studied assisted-suicide and euthanasia since 1988, especially in the Netherlands. I respond to Margaret Dore's article, which quotes me for the proposition that those who believe that legal euthanasia and/or assisted suicide will assure their "choice," are naive. ("Aid in Dying: Not Legal in Idaho; Not About Choice"). The quote is accurate. I am also very concerned to see that Compassion & Choices, formerly known as the Hemlock Society, is beginning operations in Idaho to promote "aid in dying," which is a euphemism for euthanasia and assisted-suicide.

In the Netherlands, Dutch law calls for performing euthanasia and assisted suicide with the patient's consent. This is not, however, always done. Indeed, over time, assisted-suicide on a strictly voluntary basis evolved into allowing euthanasia on an involuntary basis. Euthanasia is also performed on infants and children, who are not capable of giving consent.

2005 is the most recent year for which we have an official report from the Dutch government. The report is "spun" to defend its law, but nonetheless concedes that 550 patients (an average of 1.5 per day) were actively killed by Dutch doctors "without an explicit request." The report also concedes that an additional 20% of deaths were not reported to the authorities as required by Dutch law.

Compassion & Choices holds out the carrot of "choice" to induce the public into believing that euthanasia and assisted suicide are somehow benign. Do not be misled.

William Reichel, M.D.
Georgetown University
Washington DC

Article deserves clarification

Dear Editor:

I would like to respond to the criticism received on the article recently published in the August 2010 edition of *The Advocate* entitled "Aid in Dying: Law, Geography and Standard of Care in Idaho." The article was not intended to serve as legal advice or to suggest that, under the current state of the law in Idaho, physicians need not fear criminal prosecution or civil liability in this context. Rather, the message intended was that terminally-ill Idahoans should be able to request aid in dying from their physician, as is allowed

in Oregon, Washington, and Montana and that arguably this option is no different than what is permitted under current Idaho legislation, which empowers Idaho citizens to refuse or direct withdrawal of life-prolonging medical treatment. The intent was simply to advocate for a clarification of the law in this manner.

I would like to further clarify that, although I provided research and editing support for the article, any views expressed in the article are those of the author and are not necessarily those of my law firm.

Christine M. Salmi,
Perkins Coie, LLP
Boise, ID

Doctors should embrace aid in dying

Dear Editor:

In medical school, I occasionally met physicians who told me that they enjoyed working with their dying patients. While I accepted this as true for them, I knew it would take time and experience for me to understand.

Today, after a decade of private practice in family medicine, the grace and strength of the dying and of their families inspire me every time. I am honored to help them through this most intimate and sacred transition.

Palliative care involves relieving pain, anxiety and fear, and enabling conscious and loving communication within families. If unable to find refuge from unbearable suffering, patients with terminal illness deserve my greatest expression of empathy: empowering them to choose a comfortable and timely death.

I read Kathryn Tucker's article and heard about her presentation on end-of-life issues at the Idaho Medical Association conference in Boise in July, 2010. Ms. Tucker is a resident of Ketchum, Idaho, and Director of Legal Affairs for Compassion & Choices, a nonprofit organization dedicated to protecting and expanding the rights of terminally ill patients. Her presentation to the IMA focused on the fact that Idaho law does not address the intervention known as aid in dying. Physician aid in dying (PAD) refers to providing a mentally competent, terminally ill patient with a prescription for medication which the patient can self-administer to bring about a peaceful death if the patient finds their dying process unbearable.

Because Idaho has no statute or court decision pertaining to the practice, it is

subject to regulation as a matter of standard of care. Idaho law positions individuals as the final arbiters in decisions about their medical care. Unlike surrounding states, we have no explicit public policy on aid in dying. It is time for Idaho's medical community to unequivocally embrace aid in dying within our standard of care so that we can make PAD available to our mentally competent, terminally ill patients who choose it.

Tom Archie, MD
Hailey, ID

Elder abuse a growing problem

Dear Editor:

I am the executive director of the Euthanasia Prevention Coalition, and chair of the Euthanasia Prevention Coalition, International. Thank you for running Margaret Dore's article, "Aid in Dying: Not Legal in Idaho; Not About Choice." She correctly describes some of the many problems with physician-assisted suicide. I write to comment on elder abuse.

A 2009 report by MetLife Mature Market Institute describes elder financial abuse as a crime "growing in intensity." (See p.16.) The perpetrators are often family members, some of whom feel themselves "entitled" to the elder's assets. (pp. 13-14.) The report states that they start out with small crimes, such as stealing jewelry and blank checks, before moving on to larger items or coercing elders to sign over the deeds to their homes, change their wills, or liquidate their assets. (p. 14.) The report also states that victims "may even be murdered" by perpetrators. (p. 24.)

With assisted suicide laws in Washington and Oregon, perpetrators can instead take a "legal" route, by getting an elder to sign a lethal dose request. Once the prescription is filled, there is no supervision over the administration. As Ms. Dore describes, even if a patient struggled, "who would know?"

In Canada, a bill that would have legalized euthanasia and assisted-suicide was recently defeated in our Parliament, 228 to 59. When I spoke with lawmakers who voted against the bill, many voiced the opinion that our government's efforts should be focused on helping our citizens live with dignity, rather than developing strategies to get them out of the way.

Alex Schadenberg
Euthanasia Prevention Coalition
London ON, Canada

Delivered-To: margaretdore@margaretdore.com
Authentication-Results: mx.google.com; spf=pass (google.com: domain of alicia.a.parkman@state.or.us designates 159.121.109.42 as permitted sender) smtp.mail=alicia.a.parkman@state.or.us
X-Server-Uuid: 3D381A2D-E003-42DE-B164-A99B0781C0A0
From: "Parkman Alicia A" <alicia.a.parkman@state.or.us>
To: "Margaret Dore" <margaretdore@margaretdore.com>
cc: "BURKOVSKAIA Tamara V" <tamara.v.burkovskaia@state.or.us>
Subject: RE: Death with Dignity Act
Thread-Topic: Death with Dignity Act
Thread-Index: AQHMybnOizW1+UB22EuMxHXcInSLE5X8XnZw
Date: Wed, 4 Jan 2012 15:57:18 +0000
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X-MS-Has-Attach:
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x-originating-ip: [170.104.73.237]
X-TMWD-Spam-Summary: TS=20120104155349; ID=1; SEV=2.3.1;
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RPDID=7374723D303030312E30413031303230382E34463034373645342E303031442C73733D312C6667733D30;
CAT=NONE; CON=NONE; SIG=AAABAEUgAAAAAAAAAAAAAAAAAAAAAH0=
X-WSS-ID: 631AA9802N034901242-01-01

Thank you for your email regarding Oregon's Death with Dignity Act. For all of your questions, the answer is no. Since our office is charged with maintaining absolute confidentiality, our policy is to never release identifying information. We can neither confirm nor deny participation of any individual patient or physician. We have been contacted by law enforcement and legal representatives in the past, but have not provided identifying information of any type. To ensure confidentiality, our office does not maintain source documentation on participants.

Please let me know if you have further questions.

Thank you,
Alicia

Alicia Parkman
Mortality Research Analyst
Center for Health Statistics
Oregon Health Authority
Ph: 971-673-1150
Fax: 971-673-1201

From: Margaret Dore [mailto:margaretdore@margaretdore.com]
Sent: Monday, January 02, 2012 5:48 PM
To: alicia.a.parkman@state.or.us
Subject: Death with Dignity Act

Thank you for answering my prior questions about Oregon's death with dignity act.

I have these follow up questions:

1. Would your office release copies of completed reporting forms, e.g., a doctor's completed "Oregon Death with Dignity Act Attending Physician Follow-up Form," in response to a civil subpoena?
2. Would your office release copies of completed reporting forms in answer to a request by law enforcement?
3. Would your office confirm to law enforcement whether a person had in fact died under Oregon's Death with Dignity Act?

Margaret Dore
Law Offices of Margaret K. Dore, P.S.

Death Drugs Cause Uproar in Oregon

By SUSAN DONALDSON JAMES

Aug. 6, 2008 —

abcnews.go.com



Terminally Ill Denied Drugs for Life, But Can Opt for Suicide

The news from Barbara Wagner's doctor was bad, but the rejection letter from her insurance company was crushing.

The 64-year-old Oregon woman, whose lung cancer had been in remission, learned the disease had returned and would likely kill her. Her last hope was a \$4,000-a-month drug that her doctor prescribed for her, but the insurance company refused to pay.

What the Oregon Health Plan did agree to cover, however, were drugs for a physician-assisted death. Those drugs would cost about \$50.

"It was horrible," Wagner told ABCNews.com. "I got a letter in the mail that basically said if you want to take the pills, we will help you get that from the doctor and we will stand there and watch you die. But we won't give you the medication to live."

Critics of Oregon's decade-old Death With Dignity Law -- the only one of its kind in the nation -- have been up in arms over the indignity of her unsigned rejection letter. Even those who support Oregon's liberal law were upset.

The incident has spilled over the state border into Washington, where advocacy groups are pushing for enactment of Initiative 1000 in November, legalizing a similar assisted-death law.

Opponents say the law presents all involved with an "unacceptable conflict" and the impression that insurance companies see dying as a cost-saving measure. They say it steers those with limited finances toward assisted death.

"News of payment denial is tough enough for a terminally ill person to bear," said Steve Hopcraft, a spokesman for Compassion and Choices, a group that supports coverage of physician-assisted death.

Letter's Impact 'Devastating'

"Imagine if the recipient had pinned his hope for survival on an unproven treatment, or if this were the first time he understood the disease had entered the terminal phase. The impact of such a letter would be devastating," he told ABCNews.com.

Wagner, who had worked as a home health care worker, a waitress and a school bus driver, is divorced and lives in a low-income apartment. She said she could not afford to pay for the medication herself.

"I'm not too good today," said Wagner, a Springfield great-grandmother. "But I'm opposed to the

[assisted suicide] law. I haven't considered it, even at my lowest point."

A lifelong smoker, she was diagnosed with lung cancer in 2005 and quit. The state-run Oregon Health Plan generously paid for thousands of dollars worth of chemotherapy, radiation, a special bed and a wheelchair, according to Wagner.

The cancer went into remission, but in May, Wagner found it had returned. Her oncologist prescribed the drug Tarceva to slow its growth, giving her another four to six months to live.

But under the insurance plan, she can the only receive "palliative" or comfort care, because the drug does not meet the "five-year, 5 percent rule" -- that is, a 5 percent survival rate after five years.

A 2005 New England Journal of Medicine study found the drug erlotinib, marketed as Tarceva, does marginally improve survival for patients with advanced non-small cell lung cancer who had completed standard chemotherapy.

The median survival among patients who took erlotinib was 6.7 months compared to 4.7 months for those on placebo. At one year, 31 percent of the patients taking erlotinib were still alive compared to 22 percent of those taking the placebo.

"It's been tough," said her daughter, Susie May, who burst into tears while talking to ABCNews.com. "I was the first person my mom called when she got the letter," said May, 42. "While I was telling her, 'Mom, it will be ok,' I was crying, but trying to stay brave for her."

"I've talked to so many people who have gone through the same problems with the Oregon Health Plan," she said.

Indeed, Randy Stroup, a 53-year-old Dexter resident with terminal prostate cancer, learned recently that his doctor's request for the drug mitoxantrone had been rejected. The treatment, while not a cure, could ease Stroup's pain and extend his life by six months.

Playing With 'My Life'

"What is six months of life worth?" he asked in a report in the Eugene Register-Guard. "To me it's worth a lot. This is my life they're playing with."

The Oregon Health Plan was established in 1994 and the physician-assisted death law was enacted in 1997. The state was recently hailed by a University of Wisconsin study as having one of the nation's top pain-management policies.

The health plan, for those whose incomes fall under the poverty level, prioritizes coverage -- from prevention first, to chronic disease management, treatment of mental health, heart and cancer treatment.

"It's challenging because health care is very expensive, but that's not the real essence of our priority list," said Dr. Jeanene Smith, administrator for the Office of for Oregon's Health Policy and Research staff.

"We need evidence to say it is a good use of taxpayer's dollars," she said. "It may be expensive, but if it does wonders, we cover it."

The state also regularly evaluates and updates approvals for cancer treatments. "We look as exhaustively as we can with good peer review evidence," she said.

The health plan takes "no position" on the physician-assisted suicide law, according to spokesman Jim Sellers.

The terminally ill who qualify can receive pain medication, comfort and hospice care, "no matter what the cost," he said.

But Sellers acknowledged the letter to Wagner was a public relations blunder and something the state is "working on."

"Now we have to review to ensure sensitivity and clarity," Sellers told ABCNews.com "Not only is the patient receiving bad news, but insensitivity on top of that. This is something that requires the human touch."

Sellers said that from now on insurance officials will likely "pick up the phone and have a conversation," he said.

But a 1998 study from Georgetown University's Center for Clinical Bioethics found a strong link between cost-cutting pressures on physicians and their willingness to prescribe lethal drugs to patients -- were it legal to do so.

The study warns that there must be "a sobering degree of caution in legalizing [assisted death] in a medical care environment that is characterized by increasing pressure on physicians to control the cost of care."

Cancer drugs can cost anywhere from \$3,000 to \$6,000 a month. The cost of lethal medication, on the other hand, is about \$35 to \$50.

Advocates for the proposed Washington law say that while offering death benefits but not health care can be perceived as a cost-cutting, "respectable studies" say otherwise.

"The reason is that hospice care, where most patients are at the end of life is relatively inexpensive," Anne Martens, spokesman for Washington's Death With Dignity Initiative, told ABCNews.com.

But even those who support liberal death laws say Wagner's predicament is reflective of insurance attitudes nationwide.

Case Is Not Unique

"Her case is hardly unique," said Michigan lawyer Geoffrey Fieger, who defended Dr. Jack Kevorkian's crusade to legalize physician-assisted deaths. "In the rest of the country insurance companies are making these decisions and are not paying for suicide," Fieger told ABCNews.com.

"Involuntary choices are foisted on people all the time by virtue of denials."

"I am surprised there hasn't been a revolt in this country," he said. "It happens every day and people are helpless."

Indeed, one executive suffering from a rare and potentially fatal form of liver cancer is fighting his insurance company for coverage. Oncologists from a major teaching hospital in New York City have prescribed Sutent -- a medication that costs about \$4,000 a month and could extend his life expectancy.

"Most of my objections are that some second rate guy on the staff of the insurance company is second-guessing one of the foremost authorities and trumping his judgment," said the 57-year-old executive, who didn't want his name used to protect his privacy.

"I am fortunate to have the financial resources and the ability to fight these people who would rather these you die," he told ABCNews.com.

Dr. Jonathan Groner, clinical professor of surgery at OSU College of Medicine and Public Health in Columbus, Ohio, said some patients may want to prolong their lives for a life-cycle event, like a birth or wedding.

"A course of chemo would not cure, but would subdue the cancer long enough to be meaningful," he told ABCNEWS.com. "There are many people with slow-growing but nonetheless metastatic cancer for whom death, while inevitable, is many years away."

"The problem with the Oregon plan is it sounds like administrators, not physicians, are making treatment decisions," he said. "And if a patient can get assisted death paid for but not cancer treatment, the choice is obvious."

Derek Humphry, founder of the Hemlock Society and author of "Final Exit," who helped write the Oregon Death With Dignity Law, said only about 30 people a year choose an assisted death, which must be approved by two doctors.

"It's purely optional and the patient and doctor can walk away from it," the 78-year-old told ABCNEWS.com. "It's not the mad rush our enemies predicted and for our residents it has worked out well."

His own wife, Jean, was diagnosed with fast-growing breast cancer in 1975 and asked him to help find drugs to help her die. At 42, she chose to take them and ended her life.

Humphry says the Oregon Health Plan's approach to coverage is sound.

"People cling to life and look for every sort of crazy cure to keep alive and usually they are better off not to have done it," he said.

Meanwhile Wagner has faith in her medicine, not assisted death. Now, at the request of her doctor, the pharmaceutical company Genentech is giving her Tarceva free of charge for one year.

"The doctor did say it would put a lid on the cancer and I am hopeful," she said.

Wagner's daughter Susie May says her mother is a fighter. "I think we all knew that this is her last hope," she said.

Even Wagner's ex-husband, Dennis Wagner of Springfield, has weighed in on the ethical dilemma.

"My reaction is pretty typical," he told ABCNews.com. "I am sick and tired of the dollar being the bottom line of everything. We need to put human life above the dollar."

Rana Senol of ABC News Research contributed to this report.

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Letter noting assisted suicide raises questions



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Barbara Wagner

SPRINGFIELD, Ore. - Barbara Wagner has one wish - for more time.

"I'm not ready, I'm not ready to die," the Springfield woman said. "I've got things I'd still like to do."

Her doctor offered hope in the new chemotherapy drug Tarceva, but the Oregon Health Plan sent her a letter telling her the cancer treatment was not approved.

Instead, the letter said, the plan would pay for comfort care, including "physician aid in dying," better known as assisted suicide.

"I told them, I said, 'Who do you guys think you are?' You know, to say that you'll pay for my dying, but you won't pay to help me possibly live longer?" Wagner said.

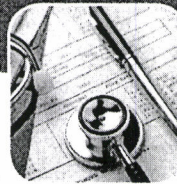
An unfortunate interpretation?

Dr. Som Saha, chairman of the commission that sets policy for the Oregon Health Plan, said Wagner is making an "unfortunate interpretation" of the letter and that no one is telling her the health plan will only pay for her to die.

But one critic of assisted suicide calls the message disturbing nonetheless.

"People deserve relief of their suffering, not giving them an overdose," said Dr. William Toffler.

NEWS RELEASE



Date: Sept. 9, 2010

Contact: Christine Stone, Oregon Public Health Information Officer; 971-673-1282, desk; 503-602-8027, cell; christine.l.stone@state.or.us.

Rising suicide rate in Oregon reaches higher than national average:

World Suicide Prevention Day is September 10

Oregon's suicide rate is 35 percent higher than the national average. The rate is 15.2 suicides per 100,000 people compared to the national rate of 11.3 per 100,000.

After decreasing in the 1990s, suicide rates have been increasing significantly since 2000, according to a new report, "Suicides in Oregon: Trends and Risk Factors," from Oregon Public Health. The report also details recommendations to prevent the number of suicides in Oregon.

"Suicide is one of the most persistent yet preventable public health problems. It is the leading cause of death from injuries – more than even from car crashes. Each year 550 people in Oregon die from suicide and 1,800 people are hospitalized for non-fatal attempts," said Lisa Millet, MPH, principal investigator, and manager of the Injury Prevention and Epidemiology Section, Oregon Public Health.

There are likely many reasons for the state's rising suicide rate, according to Millet. The single most identifiable risk factor associated with suicide is depression. Many people can manage their depression; however, stress and crisis can overwhelm their ability to cope successfully.

Stresses such as from job loss, loss of home, loss of family and friends, life transitions and also the stress veterans can experience returning home from deployment – all increase the likelihood of suicide among those who are already at risk.

"Many people often keep their depression a secret for fear of discrimination. Unfortunately, families, communities, businesses, schools and other institutions often discriminate against people with depression or other mental illness. These people will continue to die needlessly unless they have support and effective community-based mental health care," said Millet.

The report also included the following findings:

- There was a marked increase in suicides among middle-aged women. The number of women between 45 and 64 years of age who died from suicide rose 55 percent between 2000 and 2006 — from 8.2 per 100,000 to 12.8 per 100,000 respectively.
-

Suicides in Oregon

Trends and Risk Factors

Oregon Violent Death Reporting System
Injury and Violence Prevention Program
Office of Disease Prevention and Epidemiology

 | Independent. Healthy. Safe.

Oregon suicide report,
issued in September 2010. Data
through 2007. Excerpts attached.

A-60

Executive Summary

Suicide is one of Oregon's most persistent yet largely preventable public health problems. Suicide is the leading cause of injury death – there are more deaths due to suicide in Oregon than due to car crashes. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 9th leading cause of death among all Oregonians. This report provides the most current suicide statistics in Oregon that can inform prevention programs, policy, and planning. We analyzed mortality data from 1981 to 2007 and 2003 to 2007 data of Oregon Violent Death Reporting System (ORVDRS). This report presents main findings of suicide trends and risk factors in Oregon.

Key Findings

X In 2007, the age-adjusted suicide rate among Oregonians of 15.2 per 100,000 was 35 percent higher than the national average.

The rate of suicide among Oregonians has been increasing since 2000.

Suicide rates among women ages 45-64 rose 55 percent from 8.2 per 100,000 in 2000 to 12.8 per 100,000 in 2007.

X Men were 3.7 times more likely to die by suicide than women. The highest suicide rate occurred among men ages 85 and over (78.4 per 100,000). White males had the highest suicide rate among all races / ethnicity (25.6 per 100,000). Firearms were the dominant mechanism of suicide among men (62%).

Approximately 27 percent of suicides occurred among veterans. Male veterans had a higher suicide rate than non-veteran males (45.7 vs. 27.4 per 100,000). Significantly higher suicide rates were identified among male veterans ages 18-24, 35-44 and 45-54 when compared to non-veteran males. Veteran suicide victims were reported to have more physical health problems than non-veteran males.

Over 70 percent of suicide victims had a diagnosed mental disorder, alcohol and /or substance use problems, or depressed mood at time of death. Despite the high prevalence of mental health problems, less than one third of male victims and just about half of female victims were receiving treatment for mental health problems at the time of death.

Investigators suspect that 30 percent of suicide victims had used alcohol in the hours preceding their death.

The number of suicides in each month varies. But there was not a clear seasonal pattern.

Introduction

Suicide is an important public health problem in Oregon. Each year there are more than 550 Oregonians who died by suicide and more than 1800 hospitalizations due to suicide attempts. Suicide is the leading cause of injury death in Oregon with more deaths due to suicide among Oregonians than car crashes. Suicide is the second leading cause of death among Oregonians ages 15-34, and the 9th leading cause of death among all ages in Oregon¹. The cost of suicide is enormous. In 2006 alone, self-inflicted hospitalization charges exceeded 24 million dollars; and the estimate of total lifetime cost of suicide in Oregon was over 570 million dollars^{1,2}. The loss to families and communities broadens the impact of each death.

"Suicide is a multidimensional, multi-determined, and multi-factorial behavior. The risk factors associated with suicidal behaviors include biological, psychological, and social factors"³. This report provides the most current suicide statistics in Oregon, provides suicide prevention programs and planners a detailed description of suicide, examines risk factors associated with suicide and generates public health information and prevention strategies. We analyzed mortality data from 1981 to 2007 and 2003 to 2007 data from the Oregon Violent Death Reporting System (ORVDRS). This report presents findings of suicide trends and risk factors in Oregon.

Methods, data sources and limitations

X 11 Suicide is a death resulting from the intentional use of force against oneself. In this report, suicide deaths are identified according to International Classification of Diseases, Tenth Revision (ICD-10) codes for the underlying cause of deaths on death certificates. Suicide was considered with code of X60-84 and Y87.0.⁴ Deaths relating to the death with Dignity Act (physician-assisted suicides) are not classified as suicides by Oregon law and therefore are excluded from this report.

¹ Injury in Oregon, 2008 Annual Report. http://www.oregon.gov/DHS/ph/ipe/docs/report2008v2_2.pdf. Accessed on March, 26, 2010.

² Phaedra S. Corso, James A. Mercy, Thomas R. Simon et al, Medical Costs and Productivity Losses Due to Interpersonal and Self-Directed Violence in the United States. *Am J Prev Med.* 2007;32(6):474-482.

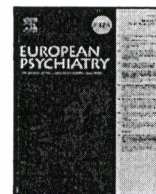
³ Ronald W Maris, Alan L. Berman, Aorton M. Silverman. (2000). *Comprehensive Textbook of suicidology*. New York: The Guilford Press. (p378)

⁴ Paulozzi LJ, Mercy J, Frazier Jr L, et al. CDC's National Violent Death Reporting System: Background and Methodology. *Injury Prevention*, 2004;10:47-52.



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Original article

Death by request in Switzerland: Posttraumatic stress disorder and complicated grief after witnessing assisted suicide

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ABSTRACT

Background: Despite continuing political, legal and moral debate on the subject, assisted suicide is permitted in only a few countries worldwide. However, few studies have examined the impact that witnessing assisted suicide has on the mental health of family members or close friends.

Methods: A cross-sectional survey of 85 family members or close friends who were present at an assisted suicide was conducted in December 2007. Full or partial Post-Traumatic Distress Disorder (PTSD; Impact of Event Scale–Revised), depression and anxiety symptoms (Brief Symptom Inventory) and complicated grief (Inventory of Complicated Grief) were assessed at 14 to 24 months post-loss.

Results: Of the 85 participants, 13% met the criteria for full PTSD (cut-off ≥ 35), 6.5% met the criteria for subthreshold PTSD (cut-off ≥ 25), and 4.9% met the criteria for complicated grief. The prevalence of depression was 16%; the prevalence of anxiety was 6%.

Conclusion: A higher prevalence of PTSD and depression was found in the present sample than has been reported for the Swiss population in general. However, the prevalence of complicated grief in the sample was comparable to that reported for the general Swiss population. Therefore, although there seemed to be no complications in the grief process, about 20% of respondents experienced full or subthreshold PTSD related to the loss of a close person through assisted suicide.

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1. Introduction

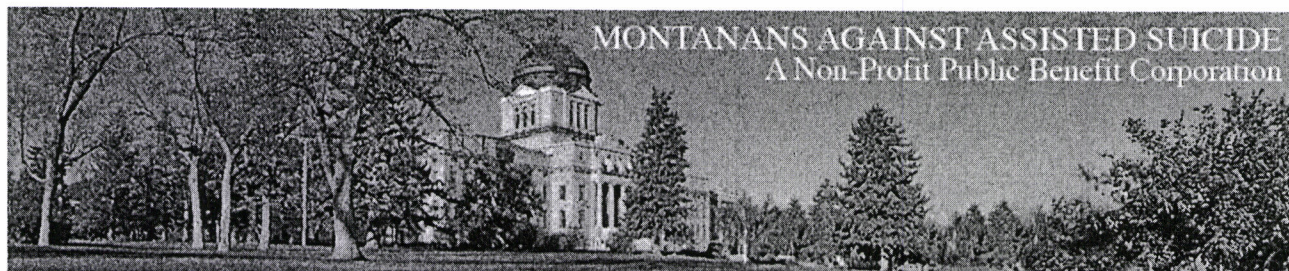
Assisted suicide and euthanasia for terminally ill patients are punishable by law almost everywhere except Switzerland, the Netherlands, Belgium and the U.S. states of Oregon and Washington. Assisted suicide is generally defined as the prescribing or supplying of drugs with the explicit intention of enabling the patient to end his or her own life. In euthanasia, in contrast, it is the physician who administers the lethal drug. In the Netherlands and Belgium, physician-assisted euthanasia is legally permitted, meaning that physicians are allowed to administer drugs to end a patient's life at his or her request. In Switzerland, in contrast, euthanasia is punishable by imprisonment (Article 114 of the Swiss penal code). It is only in the absence of self-serving motives that assisting another person's suicide is permissible. Physicians in Switzerland are therefore allowed to prescribe or supply a lethal dose of barbiturates with the explicit intention of enabling a patient they have examined to end his or her own life. However, most assisted suicides in Switzerland are conducted with the assistance of non-profit organisations [23]. These right-to-die

organisations offer personal guidance to members suffering diseases with "poor outcome" or experiencing "unbearable suffering" who wish to die.

The two largest right-to-die organisations in Switzerland are Exit Deutsche Schweiz and Dignitas. Membership of Exit Deutsche Schweiz is available only for people living in Switzerland, whereas Dignitas is also open to people from abroad. Exit Deutsche Schweiz has about 50000 members, and between 100 and 150 people die each year with the organisation's assistance. In comparison, Dignitas has about 6000 members, most of whom live abroad. A member who decides to die must first undergo a medical examination. The physician then prescribes a lethal dose of barbiturates, and the drugs are stored at the Exit headquarters until the day of use. Usually, the suicide takes place at the patient's home. On the day the member decides to die, an Exit volunteer collects the medication and takes it to the patient's home. There, he or she hands the patient the fluid to swallow. If the patient is incapable of swallowing the barbiturate, it can be self-administered by gastrostomy or intravenously [4]. After the patient has died, the Exit volunteer notifies the police. All assisted suicides are reported to the authorities. Deaths through assisted suicide are recorded as unnatural deaths and investigated by the Institute of Legal Medicine.

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E-mail address: birgit.wagner@medizin.uni-leipzig.de (B. Wagner).



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 Laws Against Assisted Suicide are Constitutional Baxter Case Analysis Letter to Physicians About Us Oregon Studies are Invalid
 Montana Constitution Does Not Include a "Right to Die" Quick Facts About Assisted Suicide MAAS Files New Lawsuit Against Board

FRIDAY, JUNE 29, 2012

A RECIPE FOR ELDER ABUSE



Julie's Sign: No assisted suicide. No assisted elder abuse. Preserve choice for seniors.

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VOICES FROM OREGON AND WASHINGTON WHERE ASSISTED SUICIDE IS LEGAL

- "I was afraid to leave my husband alone"
- "If Dr. Stevens had believed in assisted suicide, I would be dead"
- "In Oregon, the only help my patient received was a lethal prescription, intended to kill him."
- "It wasn't the father saying that he wanted to die"
- "He simply said 'Thank you.'"
- "He made the

"He made the mistake of asking for information about assisted suicide"

Dear Board of Medical Examiners:

We are disturbed to hear that the Board has been asked to legalize assisted suicide in Montana. We are writing to express our extreme objection to this development.

Our brother, Wes Olfert, recently died in Washington State where assisted suicide is legal. When he was first admitted to the hospital, he made the mistake of asking for information about assisted suicide. We say a mistake, because this set off a chain of events that interfered with his care and caused him unnecessary stress in what turned out to be the last months of his life.

By asking the question, he was given a "palliative care" consult by a doctor who heavily and continually pressured him to give up on treatment before he was ready to do so. It got so bad that Wes actually became fearful of this doctor and asked us and a friend to not leave him alone with her.

Justified or not, Wes was afraid that the doctor would do something to him or have him sign something if she would find him alone. In fact, even though he was on heavy doses of narcotic pain medications and not in a clear state of mind to sign documents without someone to advocate for him, this palliative care MD actually did try to get him to sign a DNR or "Do Not Resuscitate" form without his Durable POA or any family member present. Fortunately, his close friend / POA arrived at that moment in time to stop this from happening.

Some of the other doctors and staff members seemed to

WELCOME!

Legal physician-assisted suicide encourages people with years to live to throw away their lives.

Legal physician-assisted suicide is a recipe for elder abuse.

In Oregon, legalization allows the Oregon Health Plan to steer citizens to suicide.

In Oregon, other suicides have increased with legalization.

For more information, see Quick Facts About Assisted Suicide.

JOIN BRADLEY WILLIAMS IN THE FIGHT AGAINST ASSISTED SUICIDE



Click on photo to watch Bradley

mistake of asking for information about assisted suicide"

- "Dr. Stevens, you saved my life!" ✂

CHOICE IS AN ILLUSION



Click on the banner to learn about the fight against assisted suicide in other states ✂

MAJOR TOPICS

- Updated Quick Facts About Assisted Suicide
- MAAS Files New Lawsuit Against Board
- Physician-assisted suicide is not legal in Montana.
- Legal analysis of failed bill to legalize assisted suicide, SB 167
- Baxter case analysis ✂

BLOG ARCHIVE

- 2013 (14)
- ▼ 2012 (64)
 - December (16)
 - November (9)
 - October (8)
 - September (6)
 - August (10)
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 - False & Misleading "Aid in Dying" Letter
 - "He made the mistake of asking for information abo..."
- May (1)
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- January (2)

also write Wes off once they learned that he had asked about assisted suicide.

We object to any move by this Board to legalize assisted suicide in Montana.

We also question whether this Board would have the authority to do so. Thank you.

Ron Olfert
Marlene Deakins, RN
Sanders County, MT

Posted by Admin at 5:57 PM ✂

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Labels: aid in dying, assisted suicide, Medical Examiner Board, Physician-assisted suicide, Washington

Newer Post

Home

Older Post

Williams speak against assisted suicide ✂

PRINT OUR HANDOUTS!

- Quick Facts About Assisted Suicide
- "Aid in Dying" Whose Choice?
- Talking Points
- US Overview (Idaho article)
- Terminal Uncertainty
- Laws Against Assisted Suicide are Constitutional
- Not Legal in MT
- What People Mean When They Say They Want to Die
- Bullet Points Handout ✂

STOP ASSISTED SUICIDE



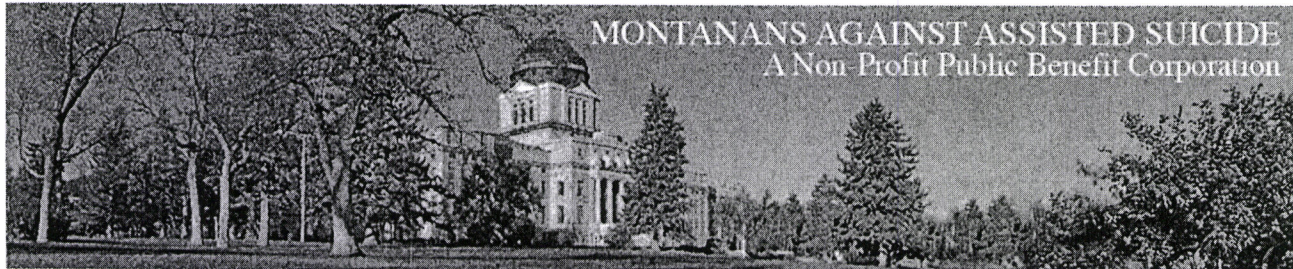
Click on the flag to learn how you can help stop assisted suicide in Montana ✂

LABELS

- aid in dying (48)
- American Medical Association (5)
- assisted suicide (73)
- Barbara Coombs Lee (3)
- Barbara Wagner (6)
- Baxter (24)
- Blewett (15)
- Bradley Williams (24)
- Bumperstickers (1)
- Carol Mungus (1)
- Charles Bentz MD (3)
- Choice is an Illusion (1)
- Compassion and Choices (9)
- Constitutional Right (1)

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TUESDAY, JANUARY 15, 2013

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"I was afraid to leave my husband alone"

Letter from Oregon resident, Kathryn Judson, Published in the Hawaii Free Press, February 15, 2011. To view the original letter, click here and scroll down towards the bottom of the page.

When my husband was seriously ill several years ago, I collapsed in a half-exhausted heap in a chair once I got him into the doctor's office, relieved that we were going to get badly needed help (or so I thought).

To my surprise and horror, during the exam I overheard the doctor giving my husband a sales pitch for assisted suicide. 'Think of what it will spare your wife, we need to think of her' he said, as a clincher.

Now, if the doctor had wanted to say 'I don't see any way I can help you, knowing what I know, and having the skills I have' that would have been one thing. If he'd wanted to opine that certain treatments weren't worth it as far as he could see, that would be one thing. But he was tempting my husband to commit suicide. And that is something different.

I was indignant that the doctor was not only trying to decide what was best for David, but also what was supposedly best for me (without even consulting me, no less).

We got a different doctor, and David lived another five years or so. But after that nightmare in the first doctor's office, and encounters with a 'death with dignity' inclined nurse, I was afraid to leave my husband alone again with doctors and nurses, for fear they'd morph from care providers to enemies, with no one around to stop them.

It's not a good thing, wondering who you can trust in a

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The Seattle Times

Jerry Large

Low-graphic news index | Mobile site

Thursday, March 8, 2012 - Page updated at 06:30 p.m.

Jerry Large

Planning for old age at a premium

By Jerry Large

Seattle Times staff columnist

Monday, I suggested exploring long-term health insurance as a way to deal with the cost of assisted living.

Like almost everything about managing when you can no longer live on your own, insurance can be complicated, frustrating and inadequate. Lots of readers shared stories about their experiences.

It was an email from a reader that led to the column. Roslyn Duffy wrote about her mother, who ran out of money and had to turn to Medicaid. She was told she'll have to move because the assisted-living facility where she lives no longer accepts Medicaid.

Care is expensive. I had no idea how costly until my wife and I began to deal with parents who needed it.

We didn't know about the paperwork and bureaucracy, or the difficult hunt for quality care that was accessible to people who hadn't managed to get rich. It's like college hunting — but with no joy attached to it.

There are good places out there, but they're harder to get into and usually cost more. Some of the most desirable places take Medicaid clients, but placements are limited.

The only certainty is that nothing is universally true.

The problem of what to do with old people who need help is a creation of modern society that we haven't committed ourselves to solving. It's almost like a monster that you don't believe exists until you answer its knock at your door.

After Monday's column, some readers were unsympathetic, a few suggested that if you couldn't save enough money to see you through your old age, you shouldn't expect society to bail you out.

At least a couple mentioned euthanasia as a solution.

But most readers were glad the topic was raised. Out of sight, out of mind is no way to deal with something so important.

So here's the deal. If you are rich, it's not a problem. If you are poor, Medicaid will pick up the tab for a nursing home.

If you are somewhere in the middle, you may want what the rich have, but be able to afford only what the poor get — and only until your money runs out, and then Medicaid will step in.

never saw anything like this before

assisted suicide

law was passed - This would be involuntary, right?